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JANUARY
1948

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VALUES OLD AND NEW
Dr. E. P. Scarlett

HOSPITAL NURSING SERVICE
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Between Ourselves

A New Year — 366 days which will be ours to fill! What shall we do with them? The president of the Canadian Nurses' Association, **Rae Chittick,** has given us a lead. If each of us goes about our daily tasks with zeal and energy, if we each put our heart, mind and soul into even the insignificant details, 1948 will be a banner year for nursing.

Dr. E. P. Scarlett amplifies these thoughts in his splendid commentary on "Values, Old and New." Faith, courage, vision and an appreciation of the deeper, the more soul-satisfying aspects of life, if coupled with ardor for our everyday jobs, will give the nursing profession the power to lift itself clear of the morass in which it has been floundering. We can if we will — we, the thousands of nurses in Canada, staunchly and intelligently studying our problems, seeking for solutions. None other can do it for us. Let us make 1948 stand out in the annals of nursing in Canada.

Completing the topic she introduced last month, **Mary L. Shepherd** has given us a compact outline of how to care for cases of communicable disease in the home. The material is detailed enough to be a useful guide for the nurse yet simple enough to be readily understood by the mother should she be in sole charge of the patient.

During the past year, the Committee on Institutional Nursing has provided us with some excellent papers dealing with personnel policies in hospitals. Speaking for the Quebec sub-committee, of which she was chairman, **Margaret M. Street** brings together many of these data and clarifies them in the light of further recommendations. Next month on this special page, Sister M. Rosarie will discuss the value of adequate supervision with emphasis on the allocation of duties.

Myasthenia gravis is sufficiently rare in occurrence that it is quite probable many nurses have not cared for a patient following a thymectomy. You will find the exposition by **Shelagh Wheeler** both interesting and instructive.

The long-promised column of nurses' boners is here at last. It is a relatively short one this time but it will give you an idea of the type of material we have been asking you for in all parts of Canada. Send us your favorites and share a **"Chuckle, P.R.N."**

We liked this comment on our November issue:

"The November *Journal* is a particularly good issue and I have much enjoyed reading and thinking over what E. MacIntosh (Trends in Nursing) and P. Campbell (Start Talking!) have written. In this day, when deeds are not enough, and words are needed, too, their articles deserve wider reading than merely that of our nursing body. I shall take pleasure in sending my copy of this issue to a well-known editor, who has always shown a sympathetic attitude to our profession."

We sometimes wonder how many of you take the time to read the **book reviews** which we publish each month. Dozens of new books are sent to us every year, books touching on every angle of our professional activity. Take, for example, the possible legal problems in which a nurse might become involved. An excellent review by a nurse and her lawyer-husband of the book, "Legal Aspects of Nursing," provided a pretty fair picture of the usefulness of this book to Canadian nurses. During last year we reviewed a grand total of fifty-two books.

It is obvious that no one person could read, thoughtfully analyze, and comment upon books covering the wide range of topics pertaining to nursing. The policy has been built up of having specialists in the various fields of nursing prepare the summations for us. In return for her courtesy and assistance, the reviewed book becomes the personal property of the nurse. While we have a considerable list of nurses who have volunteered to help us in this way, we would welcome offers of assistance from many more nurses in all branches of professional service. Will you send us your name? Please indicate the particular branch of nursing in which your interest lies. You don't know how to write a book review? Do not let that daunt you! We will give you a guide if you desire it.

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(2) Clin. Med. & Surg., 46:327, 1939;
(3) Am. J. Obst. & Gyn., 46:259, 1943;
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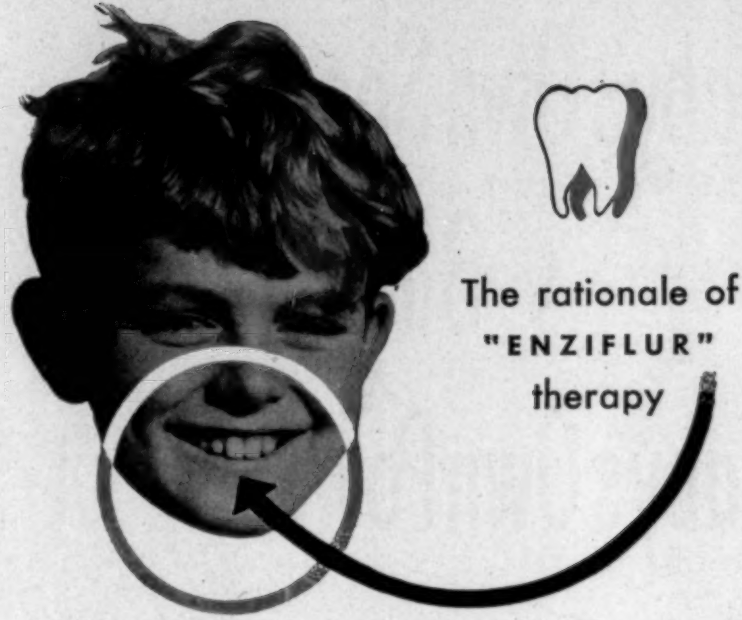

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PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-FOUR *NUMBER ONE*

MONTREAL, JANUARY, 1948

On Pulling Weeds

"IF WE could first know where we are whither we are tending, we could better judge what to do and how to do it." Almost a century has elapsed since Abraham Lincoln spoke these words, but they may be justly applied to the confusion in which we find ourselves today. Countless speakers and writers are trying to explain this confusion, and its tragic consequences — why Europe is starving, why Russia obstructs the progress of the United Nations, why China is destroying herself in civil war, why strikes and black markets cripple the economy of whole nations, and even why there is a shortage of nurses.

Each writer explains these things from his own point of view. No one, of course, can divest himself of all preconceived ideas and prejudices, so we find that the explanations vary sharply, depending upon who is making them.

But through them all there does run one common theme, one thread that can easily be picked out. The common denominators — the commonly accepted values and standards — which in previous periods of history seemed to survive in spite of wars and revolutions are today invalid. Men can no longer agree even on the most fundamental truths.

This state of affairs was aptly described by the late Raoul de Roussy de Sales: "There is no religious creed strong enough to preserve any spiritual unity. There is no universal morality. The ordinary laws of humanitarianism are not accepted by all and there is disagreement concerning the purpose and value of life itself."

In a very perceptive essay, entitled "The Constant Things," Charles Morgan puts it another way. "What has been disturbing me is the discovery that things which, by my reading of the poets and historians and philosophers, have not greatly changed their aspect in past ages are changing now . . . If mankind is really changing its view of the constant things, then the consequent revolution of the mind will be incalculably greater that any other revolution has ever been. It will strike to the roots of poetry, of religion, of the love of men and women, of human nature itself."

Morgan suggests that in this machine-dominated world, we are being detached from the real values, the constant things in life. We are becoming alien to the natural world instead of being native to it. We are losing our ability to communicate with Nature; we neither understand nor appreciate the realities of soil and sea and sky. And so are we out of tune with the Universe, and out of touch with God Himself.

Once upon a time, man's work, and indeed his whole life, was conditioned by the direction of the wind or the state of the sun, or the turn of the seasons. He was continuously in communication with them. He thought of his life and of his love in terms of their power or mercy:

When I have seen the hungry ocean gain
Advantage on the kingdom of the shore,
And the firm soil win of the watery main,
Increasing store with loss, and loss with store;
When I have seen such interchange of state,
Or state itself confounded to decay;
Ruin hath taught me thus to ruminate,
That Time will come and take my love away.

Now man's link with the natural world has been broken; soil, sea and sky are no longer his friends or enemies, his servants or masters. He measures his life in artificial terms. He makes his own summer — and his own winter. He creates his own day and somewhat more successfully, perhaps, his own night.

A report in the papers the other day told about a great new commercial building just erected in Texas. There is one remarkable thing about this building: it has no windows. The people who work in it will never see daylight. They will never see the snow fall, or the moon sail behind a cloud; they will never see the leaves tumbling off the trees, or the children playing on the grass. For the sake, one presumes, of efficiency, they must surrender part of their heritage as human beings.

This is the sad condition of present-day man — that he is disinherited. Without moral faith to guide him in his decisions, and without the natural harmony which comes from living close to the soil, he has no firm foundation on which to base his own life. But unless individual life is based on a firm foundation, the life of the whole community — right from the smallest village to the nation itself, and to associations of nations — is weak and unstable.

Modern man is confused, and nothing will help his confusion but the guidance of spiritual values. These values do not come from ideologies such as Socialism, Fascism, and Communism, since they place their emphasis on the mass rather than the individual. They encourage the citizen to think in terms of what "they" or "we" ought to do, rather than what he himself, as an individual, ought to do.

You remember the young man in Scripture who plaintively asked: "What must I do to be saved?" A great many people are asking that question today. And the answer today is as simple as the answer was then. Save yourself: do what you can in your own corner. Improve the world by improving your own small plot. People who do their work honestly and well — *no matter what that work may be* — are in actual fact creating that "brave new world" of which the writers write and the speakers speak. They are doing a little more to create it, perhaps, than the people who write and speak about it, since the creation of brave new worlds is largely a matter of patient, loyal work, with little fame and even less fortune.

The late Howard Vincent O'Brien, while fighting a losing battle with cancer in a Chicago hospital, wrote of the great world tragedies and what each of us might do to solve them: "I have an exceedingly small garden to cultivate: but it has enough weeds to demand all my attention. Keeping its soil sweet is as large a career as I can manage. This I *know:* but it is painful to admit it . . . I doubt if the world will be healed by programs, formulas, covenants, commissions or leagues. I think it will be healed when each of us does his own weed-pulling."

Few of us can make more than the humblest, the most insignificant contribution to the society in which we live. But if our hearts are in our work, if we have faith that it is worth doing, we shall have a sense of participation in the great drama of human events; we shall occupy our own peculiar place in the world. We shall know where we are and whither we are tending; we shall be able to judge what to do and how to do it.

RAE CHITTICK, *President*
Canadian Nurses' Association

Values Old and New

E. P. SCARLETT, M.D.

THIS occasion gives me an opportunity to do something which is carried out all too seldom — and that is, as a medical man, to acknowledge the privilege of having worked with nurses. I can say that it is one of the greatest happinesses of my life to have had much to do with the sensible women that make up the nursing profession. In my junior days they watched over me with tactful and maternal care. Later I came to realize that it was the nurses who set the tone of the hospital. Now that I am older, I am forever grateful for their toleration of my absent-minded shortcomings. Indeed, a good nurse is a joy forever. Too many women in these days, like those in the picture magazines, look like "Death warmed over." Nurses are a healthy corrective to this depressing spectacle. In short, no doctor can ever be a cynic about women. He has worked with nurses — and knows better.

In 1940 I spoke to a nurses' convention at which time my remarks were entitled" Till the Barrage Lifts." Well, the barrage has lifted. Our objectives have been won. But we now lift tired eyes and realize that the battle still goes on, and that the war was only the upper current of deeper moving forces struggling in the world. Our losses have been great. The price which we have paid is titanic. Our new positions must be consolidated: The desolation must be repaired. New objectives must be defined. Our ranks must be reorganized. In short, the barrage has lifted, but the war goes on. What I am going to say to you is no pleasing patter. It is "tonic and bark" — bitter, but I hope stimulating.

THE NURSING SITUATION

I have just now been paying you a compliment. But there is another side to the picture. Your profession for too long has been fed by society and by people who should know better, (I shall not call them hypocrites), on sentimental pap about the rewards of "service" (that debased word). This to my mind is thin stuff for women whose souls and bodies require something more substantial. As a result of this, and other factors, there has come about a crisis in the nursing profession. I propose only to mention this briefly, but it points to what I want to say to you.

The serious shortage of nurses at the present time and changes in our society have brought the whole organization of the nursing profession under scrutiny. Great changes are in the offing. For my part I am glad that this development has come. I have long felt that the nursing profession is one of the last relics of slavery in the modern world. To use Meredith's phrase, nurses, more than most women, are "society's hard-drilled soldiery."

Now it would seem that emancipation is on the way. The status of the nursing profession must be raised. The nurse should be more the col-

---

Dr. Scarlett is on the staff of the Calgary General Hospital, Alberta.

league and less the servant of the doctor. There should be direct contact between nurses and the governing bodies of hospitals. There must be an improvement in economic conditions, in hours of work, in better remuneration, and in a freer life for all ranks. I am confident that these changes will be affected, for two reasons if for no other. The first is that society is realizing more and more that the nursing profession is of immense and essential value to the community. And in the second place, I know that our young women still have ideals, and will continue to come forward for nursing training.

That is the situation in the nursing profession at the moment. We miss its real significance, however, unless we realize that it is the reflection of greater changes going on in the world at large. I want to talk to you about this fact, and about our place and duties as individuals in the light of the stupendous spectacle of civilization in process of dissolution, titanic change, and struggle.

The crisis in nursing, as we have said, is only part of larger issues. It is some of these that I should like to discuss briefly: What we may call the crisis in the world at large, the critical situation in the medical world, and the present crisis as it affects each one of us as individuals. Now this is a high theme, but one which I regard as most essential to discussion today. We can no longer nurse illusions. The events of the last ten years surely have shown us the terrible powers of evil and the terrifying spectacle of a world close to disintegration.

WORLD-WIDE CONFUSION

You and I may be living quite happily and comfortably at this moment. But please do not let us forget that without our ramparts the storm is raging. We are living through one of the great crises of human history. Europe and a large part of civilization are in ruins. The New World has been called in to redress the balance of the Old. The world is re-aligning, each group is desperately clinging to the security of the atom bomb, or to the entrenched power of a vast political organization. There are two ways of life emerging, loosely called Communism and Democracy, and these are confronting each other. Along with all this our material progress has been great, our progress in science has been breath-taking, but neither of these things has brought us peace or happiness.

The result is that man is confused and uncertain. Everywhere voices are crying in the wilderness telling us what must be done. Man is afraid, with the result that on all sides we hear the demand for security. Man is tired. He is disillusioned. The confidence in the sure progress of mankind which inspired men in the nineteenth century has given away to doubt. For a large section of people meaning and purpose seem to have gone out of existence.

In short, we are living in a time of troubles and discontent. It is strange that the most accurate description of the state of the world at the moment, which I have been able to find, occurs in the opening words of a great book which was written over three hundred years ago — "The Pilgrim's Progress." Incidentally, these lines constitute one of the greatest "beginnings" of a book in our literature:

> I dreamed, and behold I saw a man clothed in rags, standing in a certain place, with his back from his own house, a book in his hand, and great burden upon his back. I looked, and saw him open the book and read therein, and as he read he wept and trembled; and, not being able longer to contain, he broke out with a lamentable cry saying, "What shall I do?"

Such is the grim picture of the world today. This cannot help but affect us powerfully.

When we turn to the profession in which you and I work, we find the same transition taking place. Under the impact of new political and social ideas, great changes are underway. I only propose to point out what would seem to be the basic principal underlying these far-reaching changes.

It would seem to be this — that there is general agreement in the world today that health, like education, is a commodity which must be supplied to people irrespective of class or financial condition. Only the state can do this. So that, whether you and I like it or not, medical and nursing services are going to undergo some measure of reorganization under government control. The result means a period of readjustment stretching over many years. Stresses and strain within the framework of medical services will develop. Mistakes will be made. Many of our cherished ideas will go by the board. But with it all, new discipline will have to be forged.

When we turn to examine the state of mind and character of ourselves as human beings at the moment, even a short scrutiny is disquieting. I think it must be apparent to all of us that the old standards, backed by the Christian dispensation, which have served Western civilization for more than a thousand years, have lost their command of a large section of our people. There has been a decline in morals and manners, particularly in the last eight years. On every side one is conscious of a crude brightness that dazzles and disturbs. We are surrounded and bombarded by cheapness and vulgarity — in moving pictures, literature, music and radio. If you doubt this generalization, look over the cheap garbage to be found on any newsstand in our city. The intellectual and moral fibre of our people leaves much to be desired.

All this makes up a most gloomy picture, and I am afraid that I detect the overtones of a Jeremiah. But the fact is that the present world crisis is at bottom a moral crisis in individuals, coming on the heels of storm after storm that have beaten on an anxious civilization. However, there is no need for despair. We must keep our perspective. After all we do well to remind ourselves that the cause of human liberty has won both of the two recent great wars. An earnest endeavor is being made to set up a world order. Men and women everywhere still have courage, and are still anxious to live in fundamental decency with their fellows.

What Can We Do?

What can we do about all this? Or, in the words of Christian, already quoted, "What shall I do?" Having surveyed our world as above, what must be our course of action and the ideals which will guide us in the future?

Let us first examine our course and viewpoint as these concern the medical world. Speaking personally, I am less concerned about the organizations which nurses and doctors will form than I am about the quality of the nurses and doctors who will make up such societies. Given the right kind of nurses and doctors, the right kind of medical organization will follow. You and I — not our societies — not the system under which we practise — will be the measure of the stability of medicine, its greatness and its power to command the respect of the public. It is the individual nurse and the individual doctor that are the all-important things.

If you doubt this, let me ask you this question. What gave medicine its hold on the public esteem? You know the answer as well as I do. It was the spectacle of the self-sacrificing country doctor who was a friend of the family, and the capable self-sacrificing nurse. These, and not medical or nursing institutions, are what seized the imagination of the world and gave medicine its strength and the respect and blessing of humanity. Therein lies our strength.

In the next place, we must carry over into whatever new organization lies ahead the best of our professional ideals. We do not need to worry so much about the material things that you and I as professional folk work with — the operating-room equipment, the medicines with which we are now so richly endowed, the oxygen tents, the hypodermic injections, the techniques of nursing — these things will pretty much take care of themselves. We must, however, remind ourselves that such things are not ends in themselves; they are means by which we improve the condition of living men and women whether on the physical, mental or spiritual level.

Essentially our world is in ourselves, in our ideals, our hopes, our faith, our passions and prejudices, our intellectual achievements, our measure of charity. These are the important final considerations of our profession, and they are sustained by our sense of values, realized and expressed in our everyday work.

What are these professional values? Some at least, as I see them, may be stated. The realization that medicine is primarily concerned with the relief of suffering and the restoration of health. The duty that we owe our patients to help them to the limit of our capacity. The knowledge that in our work the fundamental things are sympathy, kindliness, a high sense of responsibility, and our obligation to give people faith and hope. It cannot be repeated too often — that the warrant-royal of our profession must remain under whatever scheme of practice it has been since the beginning: "Inasmuch as ye did it unto one of the least of these, ye have done it unto Me." So much for our professional relations. When we turn to the problem of trying to formulate for ourselves a faith and a course of action, we would do well to remind ourselves at the outset of several things. In the first place, we should realize that all of us in this hemisphere have been supremely fortunate in escaping the storms that have swept the world during the past quarter of a century. This fact should breed humility in us, a willingness to share, and, in view of the plight of the world, a determination to stand by our ideals. For it comes down to this: that we on this continent, together with a tired Britain, are the last bulwark against world chaos.

We must remember in season and out of season a truth that is being commonly flouted or forgotten: that only individuals can save society, and that no new or particular social order can save individuals. Surely our generation has learned from the bloody confusion of a war that has shaken civilization, that there are eternal value, that these are the things that endure and give meaning to life, and that these eternal values are not found in material things, but are in the realm of the spirit. What are these ideals? They are few in number. Each generation must learn and restate them for itself. Each man and woman in the last analysis must discover them for himself or herself:

Faith, first of all. Even the psychiatrists are now telling us that man is not a rational animal, but a spiritual animal. Faith is the "medicine of care," "the clue of reality," "the driving motor of life."

Courage next — and with it *work*. As one of the masters of medicine, William James, says in his great charge to mankind:

> Be not afraid of life. Believe that life is worth living, and your belief will help create the fact. The "scientific" proof that you are right may not be clear before the day of judgment . . . is reached. But the faithful fighters of this hour, or the beings that then and there will represent them, may turn to the faint-hearted, who here decline to go on, with words like those with which Henry IV greeted the tardy Crillon after a great battle had been gained: "Go hang yourself, brave Crillon! We fought at Arques, and you were not there."

Then, at all times, we must have a *vision* of the best in our minds. Saint Paul, writing to those he loved best, gave them his final charge:

> Finally, brethren, whatsoever things are true, whatsoever things are honest, whatsoever things are just, whatsoever things are pure, whatsoever things are lovely, whatsoever things are of good report; if there be any virtue, and if there be any praise, think on these things.

And, finally, we need a *religious attitude* towards life. Nearly twenty-eight hundred years ago the prophet Micah stated it:

> And what doth the Lord require of thee, but to do justly, and to love mercy, and to walk humbly with thy God.

That is a perfect statement that can never be forgotten. It should be written in the heart of every nurse and every doctor.

These, then, are the ideals which do not age or pass out of fashion. They are the foundations of the spirit of man. But, you say, what can I do alone? Well, here is the answer. It is the old story of the poor wise man as told by Ecclesiastes:

> There was a little city, and few men within it; and there came a great king against it, and besieged it, and built great bulwarks against it.
>
> Now there was found in it a poor wise man, and he, by his wisdom, delivered the city.

That is what the individual can do. My last word is this. Seven years ago I suggested as a motto for your association "Till the Barrage Lifts." May I venture to give you another parting observation. It is a paraphrase of the words with which Professor Royce used to close his lectures for the year at Harvard University: "May you be granted the wisdom to comprehend and the courage to endure, and the grace to sweeten the business of life."

Thymectomy

SHELAGH WHEELER

Myasthenia gravis is an uncommon disease of unknown cause. It occurs, as a rule, in adults, but is occasionally seen, even in its severe form, in children. It is believed that a substance called acetylcholine is produced in the neighborhood of the junction between the motor nerve endings and the muscle fibres. When the nerve is stimulated, a minute amount of acetylcholine is exploded, and this chemical change activates the muscle. The state of the myasthenic patient is very much like that of a patient with curare poisoning which produces a paralysis of voluntary muscles, and is believed to act by interfering with the response of the muscles to chemical stimulus.

To substantiate this theory, it has been demonstrated that, in the circulation of the myasthenic patient, there is a substance which can be proved to interfere with the transmission of an impulse between nerve and muscle. Another experiment shows that myasthenic serum interferes with the production of acetylcholine in the nerve cells.

The classical symptoms of myasthenia gravis are: (1) Development of profound fatigue and exhaustion at an abnormally increased rate, with rapid recovery on rest. (2) Irregular course with aggravation of symptoms and remissions of variable duration and intensity. (3) Weakness of voluntary muscles, especially those enervated by the cranial nerves.

Thymus gland: The thymus is a bi-lobed structure lying centrally in the anterior mediastinum. It is relatively largest at birth, actually largest at puberty, and gradually shrinks during the rest of the individual's life. Yet it is by no means the thread-like structure in adults that many suppose. It is usually about 2 inches long, about 1½ inches in breadth, and may weigh normally 10-20 gm. even up to the age of thirty. This relatively large gland has been a puzzle to investigators for many years. It was first mentioned by Galen, who assigned it its first function — a mechanical one of supporting the vena cava and its tributaries and protecting them from contact with the sternum. Later it was suggested that the thymus had some relation to growth, but there has been no success in an endeavor to demonstrate some active principle or hormone in the thymus related to growth. If, therefore, the thymus gland is, indeed, a member of the endocrine system, its functions are so concealed that even

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the most able investigators have been unable to distinguish them.

A connection between myasthenia gravis and the thymus gland was found first when surgery was performed upon the thymus for excision of tumors. It was found that when an epithelial tumor of the thymus occurred, the association with myasthenia was almost invariable. After the operation the doctors noted a marked improvement in the symptoms of the myasthenic patient. Although the actual role of the thymus is not known, patients having a thymectomy for myasthenia have been cured for as long as three years now, so there seems to be some hope that the results may be permanent.

HISTORY

Mr. H, aged 36 years, presented a history of general malaise and physical weakness for two months. This had been demonstrated in a weakness of the knees and jaw with difficulty in swallowing, followed by a weakness of the hands, and more recently by difficulty in expectorating. Even before the general condition had developed, weakness of the extra-ocular muscles had resulted in diplopia. During the three months previous to admission to hospital, he had lost forty pounds in weight. There was a history of cancer in the family. On admission he had a head cold which he had been unable to shake for a month. Myasthenic patients are extremely prone to respiratory infections.

On admission he presented the appearance of a large white male with a dull, disinterested expression. He was moody and easily depressed; his jaw sagged, with deviation to the right; he had great difficulty in swallowing, and expectorated large amounts of mucus; his cough was troublesome; his speech was thick and indistinct. His vision was fairly good when looking straight ahead, but diplopia troubled him when looking to either side. The pupils were unequal but he was able to weakly close his lids. The right eye pulled outward due to weakness in the muscles of the eyes. He tired very easily and complained of weakness in both hands.

FINDINGS

Urinalysis: The pre-operative results were normal. The urine was tested routinely to discover if there was any kidney infection, which would have to be cleared up before the operation could take place. This report would also be a reference following the operation should the anesthetic have had any harmful effect on the kidneys. The second urinalysis was, therefore, performed post-operatively.

Sputum: Specimens are sent routinely for all patients who cough a great deal. No acid-fast bacilli were found.

Examination of the chest: Both fluoroscopic and radiographic examinations were made with no evidence of a thymic tumor. However, the gland has to be very much enlarged to show on either side of the aorta.

X-ray examination: Swallowing was very slow and barium was retained for at least ten minutes in the pyriform sinuses, as is commonly found in myasthenia. An x-ray examination was made of the thorax two days post-operatively as the evidence suggested a cervical surgical emphysema. A spontaneous pneumothorax had occurred when a piece of lung tissue was removed (the lung had partially collapsed and air had escaped into the tissues).

Examination of specimen: The excised thymus gland measured 10 cm. by 3 cm. It was about three times normal size. On sectioning, a milky fluid exuded. The tumor was benign with no definite infiltration of the lung tissue evidenced. Marked hyperplasia of the thymus tissue was found.

PRE-OPERATIVE MEDICATIONS

Prostigmine: The action of prostigmine in alleviating myasthenia is believed to result from inactivation of cholinesterase so that acetylcholine can act in greater concentration on the muscle. This acetylcholine is necessary for a muscle-nerve stimulus and is deficient in myasthenia patients. It affects especially the craniosacral division of the autonomic system. The maximum effect occurs in half hour, and may last 6-8 hours.

As a result of the administration of this drug, the patient was able to swallow, chew, and talk much better; while without it he felt tired, could not swallow, and talked incoherently. Prostigmine is not a cure, but the lives of many have been prolonged, and nearly all have been able to live at a higher level of activity with the drug. It is only with the help of prostigmine that any operation on these patients can be safely performed.

Penicillin: Action: (1) Bacteriostatic (interferes with reproduction of organism). (2) Bactericidal (kills organism). Used in this case to reduce chance of infection, especially as in this illness patients are extremely prone to pulmonary infection. Penicillin is effective in coccic infections, syphilis, and gas gangrene. It is administered intramuscularly with special sterile technique.

PRE-OPERATIVE NURSING CARE

The pre-operative nursing care consisted of:

Relieving symptoms: The importance of rest was emphasized, especially immediately upon evidence of fatigue. A short rest period before and after meals was encouraged. In order to avoid constipation which might cause distention and result in dyspnea and restlessness, his diet was carefully chosen.

Swallowing: When admitted, Mr. H was able to swallow only small amounts of milk and jelly. A Levine tube was inserted and warmed gastrostomy feedings, followed by water to cleanse the tube, were started. By this means 8 oz. of nourishment were given every two hours during the day and every four hours at night. In addition, his tray was set up as attractively as possible for each meal to stimulate the digestive juices. Special care was given to the nose and mouth to lessen irritation.

Preparation for operation: Because of his depression, it was necessary to stimulate Mr. H as much as possible mentally in an attempt to allay apprehension and give him confidence.

No food was given for twelve hours preoperatively since the probable irritation of the lining of the stomach by the anesthetic would promote vomiting. A soap-suds enema was given the night before the operation to avoid post-operative distention and to eliminate the possibility of involuntary defecation when the sphincters were relaxed under the anesthetic.

The skin preparation consisted of shaving the patient from the umbilicus up over the chin and from bed-line to bed-line. Hair cannot be sterilized so shaving reduces the possibility of infection. The patient was given an opportunity to void before going to the operating-room in order to avoid involuntary micturition under the anesthetic.

OPERATION

An incision was made in the midline over the sternum through the periosteum to the bone. The sternum was split completely, the connective tissues divided, and the gland excised along with a small portion of pleura, about the size of a quarter, to which the tumor had adhered. The incision was closed, and a Penrose drain brought through the sternum to the surface at the lower end of the incision.

THE POST-OPERATIVE PATIENT

When he returned from the operating-room, Mr. H was perspiring profusely, his temperature was elevated during that day, his respirations were deep, and he expectorated a large amount of clear, thick mucus. He was able to take orange juice, cream of wheat and milk. The left side of his face was swollen and his left eye partially closed due to surgical emphysema.

During the next three days Mr. H continued to perspire profusely and his face was flushed. This may have been due to the ephedrine which dilates the superficial blood vessels and thus stimulates perspiration. Since the muscles of respiration were weak, he had difficulty in breathing when lying on his back. His cough was very troublesome so ephedrine was given. He was able to raise considerable amounts of thick, blood-tinged mucus. His left eye was still puffy, both cheeks being swollen. His face and hands twitched at times while he was dozing.

By the fifth day Mr. H was perspiring much less profusely, his cough was much less severe though the mucus was still slightly troublesome. There was no evidence of dyspnea or diplopia, the pupils were equal, and the vision in general was improved. He was able to take full diet and fatigue was much less pronounced. Mr. H was allowed to be up and to walk around the ward.

POST-OPERATIVE NURSING CARE

This operation demands that the patient lie either flat in bed or sit straight up so that the mucus will drain out of the mouth. Mr. H was kept flat and his position was changed frequently from side to side to avoid post-operative pneumonia. Electric suction was used to relieve the mucus. Because of the profuse perspiration, it was important to shield Mr. H from draughts and to provide light, sufficiently warm bedding. It was necessary to change the bed frequently as the sheets became saturated with perspiration.

An intravenous injection of 500 cc. of blood had been started in the operating-room and was completed on the ward to replace that lost during the operation. The patient was carefully watched for shock, hemorrhage, etc. As consciousness returned, it was necessary to watch him carefully to prevent any violent movement which would have been harmful. As soon as Mr. H could swallow, fluids were forced to replace the operative loss and the waste from perspiration. A total of 3,500 cc. of fluid was recorded. Pain in the operative area was relieved by morphia ¼ gr.

Mr. H was unable to void for some hours despite the application of external heat and the fact that he was permitted to sit up on the edge of the bed in order to encourage normal action. He was catheterized, 14 oz. of urine being obtained. When the dressing was changed, considerable bright oozing was noted from the Penrose drain at the lower end of the incision.

As a precaution against a possible respiratory crisis, an artificial respirator was placed in his room for the first post-operative day. By the second day the patient was able to turn himself frequently without much assistance. Rest was encouraged by the administration of nembutal. The excessive perspiration continued and dyspnea and the cough were troublesome. An oxygen mask was used occasionally to relieve the dyspnea. The foot of the bed was elevated to help the drainage of the mucus and to relieve the cough. Codeine gr. 1 was given by mouth in order to depress the cough centre. Ephedrine q. 6 h. and adrenalin when necessary to relax bronchial muscles and facilitate breathing were ordered. During the second and third day the dressings were changed frequently. They were found to be saturated with a sero-sanguinous discharge. The drain was removed. The incision was clean. Mr. H was unable to void and was given carbachol amp. 1. This diuretic finally induced normal voiding. Because of cramp-like pains in the abdomen, Mr. H was given a Mayo enema. Considerable flatus was expelled and the pain relieved. During this period prostigmine was administered 5 mgm. q. 3. h. as Mr. H was having a little difficulty in swallowing.

On the fifth and sixth days prostigmine bromide 15 mgm. was started q. 3. h. This was administered in tablet form so that the patient could take them at home by himself.

To relieve the surgical emphysema, the doctor aspirated 500 cc. of air from the chest. After this air was removed, the puffiness of the tissues of the neck and face gradually receded. Mr. H. was allowed to sit up in a chair for short periods, but care was taken to see that he did not become fatigued. On the third day Mr. H was able to tolerate a soft diet.

During the fifth and sixth days the discharge from the incision became much less, Mr. H was allowed up in a chair for half an hour at a time and was able to walk to the bathroom without assistance.

The important points of health teaching which were emphasized to him were to avoid fatigue by not over-doing muscular activity; to get as much sleep as possible with a nap during the day; to avoid extremes of heat and cold and thus prevent infections of the upper respiratory tract; to take medications exactly as instructed.

PROGNOSIS

It is difficult to classify results since there is no uniformity in the manifestations of myasthenia gravis. The results of forty-one operations have been catalogued into categories as follows:

Group A— Quite well. Normal life without prostigmine: 9 patients.

Group B — Greatly improved but needing some prostigmine: 11 patients.

Group C — Somewhat improved. Prostigmine less helpful than before: 8 patients.

Group D — No improvement: 5 patients.

Group E — Post-operative deaths: 8 patients.

It has been found that about one patient in ten has a tumor. The prognosis for patients with tumors is much poorer than for those without. All patients with tumors tend to react more slowly and incompletely to prostigmine. Young patients with shorter histories of illness give a better response than the older patients in the above grouping. The youngest patient was 15 years, the oldest 54 years, the majority ranging between 21 and 40.

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Communicable Disease Care

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THE HOME CASE

NOT ALL communicable disease patients are admitted to hospital for care. Many of these cases will be visited by public health nurses who will have to give instructions to the mother on how to care for the patient. Occasionally, a private duty nurse will be called to provide this care in the home. It is important, therefore, that every student nurse should be familiar with the adaptations of communicable disease nursing techniques which are necessary to provide efficient home care. If, for example, the patient is an only child and no one goes out to work, the problem will be very different from the home where there are several children all of whom might be susceptible. Good nursing care in the home situation demands the same protection against the spread of infection as is practised in hospitals. Moreover, the nurse, while working in the home, has an unparalleled opportunity to give valuable health instruction.

It is important that the nurse should familiarize herself with the regulations governing the control of communicable disease in the city or town in which she happens to be working. Placarding of houses, the responsibility of the local department of health, and quarantine regulations are a few of the important items she should learn. Many private duty nurses refuse to accept calls to care for communicable disease patients in their homes, because they feel that their knowledge and experience are inadequate for the work. In every case she may consult with the physician regarding the aseptic technique to be observed, but there are certain fundamental applications which she should know.

Preparation for the patient: A sunny, well-ventilated room, as isolated as possible from the rest of the family, is essential. The unit should be arranged close to the bathroom if possible. Remembering that droplets from a cough or sneeze may travel a distance up to ten feet, everything within that range of the patient's bed should be considered contaminated. Cheerful surroundings contribute to the patient's happiness so curtains which can be laundered may be left on the windows; pictures which can be washed may be left on the walls. During the warm months, adequate screening should be provided for the windows to keep out flies and other insects. Steps should be taken to prevent household pets from entering the sickroom.

In the majority of private homes there is only one bathroom so all equipment should be kept in the patient's room. The dresser top may be protected with oilcloth or newspaper then covered with a washable linen runner. Clean dressings, uncontaminated linen, etc., may be kept in a dresser drawer. A table for the convenience of the nurse and the patient may be placed at the bedside. A waste pail will prove useful.

For the safety of other members of the household all surfaces, including especially the taps, toilet flushers, washbowl, doorknobs, and electric light switches should be kept free from contamination. The nurse or attendant must remove her gown in the patient's room before entering the bathroom. Care should be used in holding contaminated articles so that they do not touch any clean surfaces. The nurse should use squares of paper (newspaper, toilet tissue, Kleenex) when it is necessary for her to touch *anything* in the family bathroom, the square being discarded into the flushing toilet.

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Care of the patient: The nurse or parent should wear a protective covering — gown, Hoover apron, or short-sleeved smock. This should be kept on a stand in the patient's room and put on whenever care is given. All of the equipment necessary for care should be assembled before the actual care is given. This includes such items as: bath water, washbowl, cup of mouthwash, a basin to receive the expectorations, towels and washcloths, the waste pail, etc. Newspapers may be placed on a chair to receive the soiled linens. The clean linen is removed from the drawer. No receptacles should be placed outside the bedroom where curious children may pry into them.

The actual nursing care is similar to that given in hospital. Any treatments which have been ordered should be carried out carefully. Special attention should be given to the cleansing of the mouth. Contaminated linen and dishes should be boiled before being washed. Papers, letters, etc., should be burned.

Discharging the patient: The usual discharge bath, accompanied by a thorough shampoo, is given. After the patient is dressed in clean clothes he should be placed in another room and the usual details of terminal disinfection attended to at once. Washable surfaces and objects should be washed with soap and hot water. The walls in many homes are papered so washing them is impracticable. Such rooms must be thoroughly aired. Blankets and curtains should be washed and dried in the sun.

Health education: The nurse must remember that the most easily-followed form of instruction is the example which she sets. Verbal teaching throughout should be simple, clear, reasonable, and adapted to the immediate situation. The family should learn the reasons for all of the precautions that are taken and appreciate their importance in the protection of the well members. An opportunity is given the nurse to stress immunization as a means of preventing many of the communicable diseases.

CONDENSED INSTRUCTIONS

Familiarity with the following main points in the nursing care of the commoner communicable diseases, including tuberculosis, will assist the nurse whether in hospital or in a home:

Chickenpox: (1) Isolate. (2) Frequent tub baths, unless temperature elevated. (3) Full diet.

Laryngeal diphtheria: (1) Isolate. (2) Assist doctor in giving diphtheria antitoxin. (3) Keep patient lying down in bed. (4) Quiet. (5) Watch very closely. (6) Place in steam room if respirations difficult. (7) Fresh air.

Laryngeal diphtheria (intubated case): (Where hard rubber tube is inserted through the mouth into the larynx to relieve dyspnea.) (1) Isolate. (2) Nurse must never leave patient for a moment. (3) Watch patient closely for cyanosis, dyspnea, and restlessness which may denote the blockage of the tube or that the tube has slipped out of place. (4) If the above symptoms occur, remove the tube and call a doctor at once. Take child immediately to intubating room if symptoms continue. (5) Prevent the patient from pulling the tube out by the silk string attached to the cheek. (Restrain hands if necessary but never have patient in restraint for fear of sudden dyspnea.) (6) To remove the tube, pull by silk string attached to cheek. If string chewed off, call a doctor to extubate. (7) Feed child in sips to avoid coughing as coughing may dislodge the tube. (8) Keep the patient lying down and quiet at all times. (9) Nursing care otherwise as for other diseases.

Diphtheria (tracheotomy care): (1) Patient isolated. (2) Keep patient lying down and quiet. (3) Remain with small children and with adults until they become adjusted to tube. (4) Watch patients closely for cyanosis, dyspnea, etc. (5) Diet as ordered. (6) Keep a moist dressing over the tube. (7) Keep a split, sterile dressing under the tube. (8) Remove the inner tube frequently and clean with pipe cleaner.

Pharyngeal diphtheria: (1) Isolate. (2) Assist doctor in giving the diphtheria antitoxin. (3) Complete bed rest with patient lying down. Patient to be fed and given complete nursing care, to try to avoid complications. (4) Fluid diet. Because of the edema of the throat and the extensive membrane which may be present the patient has difficulty in swallowing. (5) Frequent hot gargles because of the throat involvement. (6) Complete bed care given until otherwise ordered by doctor.

Erysipelas: (1) Isolate. (2) Bed care until otherwise ordered by doctor. (3) Treatments and medications as ordered. (4) Fluid diet, gradually increased. (5) Eye bathings.

German measles: (1) In hospital only about four days. (2) No treatment.

Measles: (1) Isolate. (2) Care of the eyes: (a) darken room; (b) no reading; (c) other treatment as ordered. (3) Frequent hot sponges. (4) Keep in bed and warm. (5) Fluid diet and gradually increase.

Meningitis: (1) Isolate. (2) Medications and treatments as ordered by doctor. (3) Assist doctor with lumbar punctures. (4) Complete bed care. (5) Hot sponges to make patients more comfortable as he is usually very ill. (6) Fluid diet or given intravenously. Diet very important because of emaciation which may quickly develop. (7) Care of the mouth as patient too ill to do anything for himself. (8) Special care to the back as it makes the patient more comfortable, particularly where there is marked loss of weight. (9) Keep the patient as quiet as possible as he is usually extremely sensitive to noise or outside stimuli. (10) Watch closely. (11) Ice cap or cold compresses may be applied for headache.

Mumps: (1) Isolate. (2) Keep in bed until allowed up by doctor. (3) Treatment and medications as ordered. (4) Hot water bottle if desired. (5) Diet as tolerated.

Scarlet fever: (1) Isolate. (2) Assist doctor in giving scarlet fever antitoxin. (3) Keep patient in bed and warm until allowed up by doctor. (4) Daily hot sponges. (5) Frequent gargles. (6) Fluid diet, then gradually increase.

Smallpox: (1) Isolate. (2) For the comfort of the patient: (a) complete bed care; (b) warm, light clothing; (c) cradle over bed if pocks causing irritation; (d) hot water bottle for backache; (e) ice caps for headache; (f) care to mouth, nose, and eyes particularly if patient very ill; (g) local treatment for irritation as ordered by doctor. (3) To maintain patient's strength: (a) nasal-fed or given intravenously but patient must get necessary fluids. Gradually increase diet when able to take it.

Whooping cough: (1) Isolate. (2) Remain with small children during coughing spasms. (3) Allow dressed on bed or out of bed if possible, unless temperature elevated. (4) Avoid excitement as this causes coughing spells. (5) Give food in small amounts frequently. (6) Other treatment as ordered.

Tuberculosis: (1) Rest: (a) in bed until otherwise ordered, then graduated exercise; (b) definite rest periods in morning and afternoon. (2) Fresh air. (3) Diet: (a) good nourishing food; (b) simple, attractively served; (c) milk or other fluids between meals. Diet important because of loss of weight. (4) Restriction of visitors: (a) definite visiting hours; (b) only two visitors at a time; (c) small children not allowed in because of susceptibility to disease. (5) Teach the patient: (a) the value of rest and good nursing care; (b) the careful handling of sputum boxes and Kleenex; (c) to cover mouth when coughing and sneezing. (6) Full sponges weekly, to conserve patient's strength. (7) Special care to back, particularly those in bed over long periods. (8) Occupational therapy when allowed by doctor.

Effect of Family Allowances

Though this experiment is still too brief to permit conclusive statistical measurements of the various possible welfare aspects of the program, *The Labour Gazette*, October, 1947, has published some data following cross-section surveys by the welfare supervisors in each of the nine regional offices. Recipients of family allowances were chosen in such a way as to get a good sample, including families in a variety of districts and at various income levels. These surveys indicated that family allowances are being used by families in various ways, to provide such benefits as: Improvement in diet, especially extra milk and fruits, oranges in particular; more adequate clothing; extension in use of medical, dental, and optical services; and in some cases widening of recreational or cultural opportunities. An increase in school attendance has been noted by school authorities since the allowance is not payable for a child who, being of an age when he is required to attend school by the laws of the province where he resides, and physically fit to attend school, fails to do so or to receive approval of equivalent training.

The Metropolitan School of Nursing

Now that more detailed information is available regarding the new course which is starting in conjunction with the Metropolitan Hospital in Windsor, Ont., it is possible to provide the readers of *The Canadian Nurse* with additional information regarding this project. It will be recalled that the purpose of the school is to give the basic education for professional nursing and a recognized background for post-graduate study in public health or nursing education in fewer months than the regular undergraduate course takes.

The admission requirements have been set at the level of the Ontario secondary school graduation diploma (Grade 12) or equivalent certificates from other provinces as determined by the Department of Education. The essential thing is that the candidate shall have the requirements necessary for entrance to a university in her own province. Eighteen years has been set as the minimum age for admission.

Special forms of application have been prepared which candidates are required to file with the secretary of the School of Nursing, 849 Kildare Road, Windsor, Ont. A personal interview is regarded as an essential part of the application. Where candidates reside at too great a distance from Windsor to make the interview with the school director practicable, special arrangements will be made. In addition to the application the candidate must submit her Department of Education certificates, an official certificate of birth, and a certificate of successful vaccination.

Since this course is planned along the lines of a truly educational experience, the students will pay fees just as university students do. Fees have been set at $50 per year to include tuition, health service, and incidental expenses. Travelling expenses to other centres for affiliated experience will cost the student approximately $25. Board and lodging are supplied by the school when the student lives in residence. Students are expected to live in residence during the entire course unless other arrangements are provided by the school.

As has been announced the course is planned to cover a period of twenty-five months, including vacation; but no absolute guarantee can be given that one or two months more may be found necessary. Certain subjects will be taught directly at stated times in the course. Other subjects, including mental hygiene, nutrition, public health, or preventive medicine, will be associated at all times with the teaching of the subject of nursing and with nursing practice. Practice of nursing in medical and surgical wards will be provided at particular periods but it should also be noted that almost every other hospital service (pediatrics, obstetrics, tuberculosis, etc.) provides continued practice in medical nursing, in surgical nursing, or in both. The course as planned meets requirements for nurse registration in the province of Ontario and will make candidates eligible for registration by reciprocity in all other provinces.

As it is the duty of nursing schools to remove hazards for health as far as they can be seen and controlled, careful attention will be given to this matter by the school. Before admission to the course the candidate must submit a report testifying to her general good health. On entering the school she must bring a report (on the form provided) of recent immunization against smallpox and typhoid fever, of recent testing of susceptibility to diphtheria and scarlet fever and immunization against these if she is susceptible. During the course physical examinations will be arranged annually. X-ray examinations of the chest will be made at the opening of the first term and at six-month intervals thereafter. Provision is being made that, should illness of a slight nature occur, the student will be cared for in the school residence. If medical care or hospitalization is necessary, the student will be required to pay the costs.

A vacation of one month each year, plus provision for statutory holidays, has been arranged. Excepting under special circumstances leaves of absence will not be permitted, especially for the purpose of nursing sick friends or relatives.

Students will provide their own uniforms for the hospital work. Arrangements have been completed to have these made in Windsor under the direction of the school. The necessary articles of the preliminary outfit include: 6 dresses, 6 caps, a cape, white stockings, and 2 pairs of plain low-heeled oxford shoes. There is no prescribed make of shoe. The cost of this preliminary outfit is estimated at between $75 and $80. When necessary the student will be required to add dresses at an approximate cost of $6.00 each.

Students will be required to attend the courses of instruction and the examinations prescribed for their respective groups. No student will be permitted to remain in the school who persistently neglects academic work. Similarly, satisfactory progress in practical work in the hospital and in the public health field will be required at all times. No student will be allowed to continue in attendance whose presence is deemed to be prejudicial to the interests of the school. Examinations will be scheduled as in other courses in nursing. A candidate who has obtained standing in these examinations but who has failed in one subject may write a supplemental examination in which the pass mark in each supplemental examination subject will be the same as for the regular examinations. Should a student fail in the final examination of a subject and also in the supplemental examination of that subject, she will not be allowed to write a further supplemental examination without repeating the regular work of this subject during the session of the school.

Economy in time, money and substance is the aim in this school, the first radical change in nurses' training in a century. The school will be separate from the hospital, but there will be complete co-operation between the two bodies.

Hospital Nursing Service

BERTHA L. PULLEN

WE HAVE all learned in the past few years that the best of theories and practices break down in great crises. There is no royal road to quality nursing service. The tortuous path over which quality nursing service climbed to its pre-war heights fell into disrepute during the war. Why? Because many of the nurses, with their careful three years' scientific and technical grounding in sound nursing practices, were suddenly swept from us to enter the military service, and it was necessary to replace them with short-course *volunteer* aides, who were enthusiastic, willing and sincere, to be sure. How would we have ever carried on without them? But their hours were limited to their personal convenience. We had no hold on their time. We were not free to demand that quality of service we would have required of our paid employees, for fear we would lose them. This can happen for a few months or a year without material damage to philosophies, ideals, and standards of work, but when it continues over the total time of a student nurse's three-year course, (and this crisis spanned the complete course of five classes of nurses), it begins to undermine all standards and under-

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standing of good nursing practice. None of our young graduates since 1942 have known, by precept or example, what normal, standard, high quality nursing is. This is said with all admiration for the yeoman service of those fine and loyal graduates who stayed by the hospital. This younger group is largely filling our present needs. Little wonder that with too few nurses and too much work, they are looking for the shortest hours possible, with minimal responsibility and high salaries.

At the present time nursing service is showing all of the symptoms of a full-blown neurosis of the anxiety type. Personnel are emotional, unstable, irresponsible, disinterested, egocentric, irritated, sensitive, and self-pitying. There are days when everything runs smoothly and hope runs high, followed by days of anxiety, lassitude and indifference. How are we ever going to correct this service of peaks and valleys and maintain a level complement of nursing service?

Professor Lambert, formerly instructor in mental hygiene at Columbia University, used to tell his students that life was like a woman's old-fashioned petticoat. With each additional degree of education which we acquired, we added a row of lace to the skirt. The more highly civilized we were, the wider the lace. When life became too complicated for us, the lace began to wear off in those spots where it was the weakest, and if measures were not taken to mend it, the lace finally wore down to the hem and then attacked the basic garment.

Pre-war hospitals became so top-heavy with nursing service that fundamental nursing care was almost submerged with the details of high class hotel service. When war conditions began to tear away the frills of service, it was difficult for the public to understand that the frills of nursing service were not the fundamentals of nursing care. But, if we do not take measures to remedy our weak and frayed service, before it reaches the very foundation of our institution, we may find that it is too late to prevent permanent abnormal injury to good nursing care. Every patient, regardless of his ability to pay, is entitled to adequate and safe nursing care but, if patients come into a hospital expecting first class hotel service in addition to adequate nursing care, then they should be educated to understand that they will have to pay for it. A high salaried nurse's time should not be wasted on such details.

Every institution is based on aims and objectives and has policies and definite functions. However, they may not always be sound ones. In an article in the *American Journal of Nursing*, Erma Holtzhausen suggests that the objectives of the traditional school of nursing are: (1) to prepare students to practise nursing; (2) to provide a nursing service at the lowest cost possible to the hospital sick. These objectives have always been in conflict. They have placed the students' professional education in competition with the needs of the hospital. The specific demands and conditions of each have made accomplishment of the other impossible. To guarantee a service that is regular, continuous, adaptable, with completely competent and safe nursing of patients by a student group, is impossible if one must provide at the same time for free participation by the student in an educational program that is academically and professional sound.

Nursing education has its philosophies, aims, standards, studies, and curricula. *Nursing service*, too, has philosophies, aims, standards, studies, and programs of work. In nursing education, the student is at the centre of the program, whereas hospital nursing service revolves around the patient. Nursing education should exist as a school in its own right and not be hampered by service needs. Nursing service should not be required to put aside its major aims of service to the patient for the sake of the student. As long as nursing service must depend on a split personality and be torn between two loyalties, we will continue to seek a compromise, have periods of hysteria, then depression and sometimes suicide.

Once more we must start and build a new road for quality nursing service to travel. To be sure the structure will probably be changed but the basic philosophy, principles, and objectives will be the same. Before we can rebuild nursing service, we should determine in our own mind what it is, and know what we are going to build. What is included in nursing service will vary with the size, type, and organization of every hospital.

Webster defines "service" as "a performance of labor for the benefit of another; a supply of a need; to prove oneself adequate and satisfactory." He defines "nursing" as "a person giving curative care and treatment to the sick." He defines "care" as "a sense of responsibility or watchful attention." A "profession" is "a calling in which one professes to have acquired special knowledge to be used for serving others in some art."

Can we say then, that the philosophy of nursing service is based on a desire to help the physically and mentally frustrated person to re-establish himself to a normal and happy, well-adjusted economic entity? Can we say that our objective in nursing service is to provide that type of nursing care, treatment, and service that will enable the patient to spend all of his effort in getting well? Can we say that the functions of nursing service are:

> To provide a clean, cheerful, quiet harmonious environment for the patient; to provide adequate nursing care for the most rapid and satisfactory recovery possible; to co-operate with the doctors, family, and other departments of the hospital in the care of the patient; to understand the purposes and functions of other departments of the hospital, their relationship to the patients' care, and the importance of adjusting our service to promote optimum service in all other departments; to understand the traditions, to uphold the ideals, philosophies, and standards of work of the institution in which we are working; to establish and maintain lines of authority and develop a harmonious relationship among the personnel of our department; to employ and train an adequate number of qualified personnel to carry out the various functions of our service; to outline the duties of the personnel; to secure information in relation to the number of patients requiring care in the different divisions of the hospital and the conditions to be cared for; to investigate complaints in relation to patients' care, etc.

We must not confuse nursing service and nursing care. "There is a vast difference between services rendered to patients by nurses and the actual professional nursing care." Nursing care has been defined as "adopting prescribed therapy and preventive treatment to the physical and psychic needs of a patient." It assumes that such care carries with it skilled practices, serious responsibilities, watchful attention, and keen observation. It, therefore, should be administered through highly qualified professional nursing practice. Whereas, nursing service not only covers all of the foregoing, but includes innumerable other duties that are necessary to the efficient and economic functioning of the institution, such as errands to the x-ray, pharmacy, physical therapy, dietary, housekeeping, purchasing departments, keeping the patients' environment clean and attractive, serving meals, attending to relatives, keeping records, giving baths, keeping up supplies, maintaining equipment, making out work lists, caring for flowers, listening to grievances, caring for patients' clothing, keeping utility rooms clean, cleaning up units after patients have been discharged. Does all of this require the services of a highly skilled professional nurse? Obviously the answer is "no." If not a highly skilled professional worker, what type of worker do we need? We should have a person with average intelligence who can follow directions, who is capable of being taught routine manual duties of ward housekeeping, bed-making, giving baths, etc., and whose emotional stability is sufficient to keep her from being a menace and annoyance to the patients. Quality of nursing will depend on the quality of mentality which renders it. If large portions of routine, non-technical nursing service are to be turned over to non-professional workers, we must be very sure that such people are safe to be around patients. If they are people whose home background, mental limitations, and aversion to self-discipline have been sufficient to cause them to leave school at an early age, and later seek nursing as a means of livelihood, then we can be sure that we will have limited, maladjusted and irresponsible, dangerous nursing service. Such service will of necessity require supervision by an exceptionally, well-prepared and able, professional nurse. It takes far more competence and a better prepared person to supervise and understand this type of worker, than it does to supervise the more highly qualified person.

The doctor's knowledge of his service in the hospital is dependent upon what the nurse observes and reports, and much of his treatment is dependent upon this. If the nurse fails to observe and reports nothing, then he may fail in his treatment.

"Recent studies have shown that a large portion of the duties performed by a general duty nurse could be performed by a less highly educated person under proper supervision. If that is the case, then it is very poor hospital economy to be paying professional salaries for non-professional work. Intelligent, safe and satisfying bedside nursing is the foundation of good hospital nursing service." The sooner we get on with the business of defining the functions and preparation of the non-professional worker, so that we can put her to work at her task and not have the hospital and schools of nursing discredited for frankly doing so, the quicker the registered nurse can be relieved of the maid's work and get on with the task she is prepared to do, and the quicker nursing service in hospitals will become stabilized, nursing care improved, and professional nursing will fall into its proper place.

You will ask, "What type of person should do this work and what shall we call her?" Is it important what we call her, except that she does not practise under the guise of something she is not? The public have been educated to go to the hospital when they are ill, as it is purported to be a place where they have specially qualified professional nurses, who know how to meet every emergency and are better prepared to take care of patients than they can be cared for in their own homes. If we are going to dilute this service with a less well prepared person, then we must be very frank and let the public know what they are getting. This auxiliary worker must be as carefully chosen from the standpoint of intelligence, stability, interest, health, physical fitness, adjustability, etc., as the student or graduate nurse. Our ethical and social practices in life are largely those we have learned at our mother's knee. Some of those practices are good and some are questionable. The only way we can protect the helpless sick against questionable practices and people who are unfit to practise, is by setting minimum requirements in education and laws that will require these people to have certain minimum preparation, which will stipulate what they are prepared to do and what they may *not* do. If such a non-professional person is employed in an institution, she should work under supervision at all times, and all of her functions should be carefully delineated and supervised.

You may say, "What are we going to do in the small hospital? We cannot afford this highly specialized service." We must realize that just as many problems can arise in a small hospital as in a large one. The small hospital does not have the social worker, psychiatrist, specialists, and numerous other kinds of specialized departments to turn to for help, and the nurse who has to take charge of a small hospital must be a person with initiative, resourcefulness, judgment, perspicacity, and daring courage to assume such a responsibility. We must realize that the basic education and experience which the mass of our employees have in elementary school is not adequate to prepare them to cope with the complicated situations of even the small hospital, where not only the physical needs of the patient must be met, but also the mental and emotional needs. The nurse has to step into the emergency and be the nurse, the social worker, the dietitian, the cook, and anyone else who fails to turn up.

Public disapproval and past standards in hospital service, and past ideologies about medical and nursing practice, are inhibiting our clear thinking about nursing service. The social unrest and the remnants of recent high salaries for unskilled labor paid to the meagrely educated masses, who are still seeking an Alice-in-Wonderland Utopia as an escape from their own personal inadequacy and maladjustment, are blocking organized efforts that we are making towards supplementary professional nursing. Unskilled labor is still hoping for assembly-line salaries while wielding a dust cloth, and this is impossible.

Regardless of what our present deficiencies and shortages are, we must have some guiding principles and goals toward which we can strive if we ever hope to pull ourselves out of the slough of despond:

The first principle is to *face reality* and take what we have and work out the best possible service with it.

The second principle is to be *tolerant and understanding* of those who are trying to do their best with limited native endowment.

The third principle is to *teach each person how to do her job* to the best of her ability.

The fourth principle is to make each person feel that her *job is important* and she is a very necessary part of the institution.

You may be pleasantly surprised at what you can develop if you conscientiously set about doing this. However, since the nursing service of tomorrow is the product of the precept and example we set for the student of today, it behooves us to move cautiously and plan soundly.

Who is responsible for nursing service? — the superintendent of nurses, her immediate assistants, supervisors, head nurses, general duty nurses, student nurses, practical nurses, ward maids, orderlies, etc. The quality of nursing service will depend upon the quality of the people who are rendering it from the superintendent of nurses to the cleaning maid. Quality depends on workmanship, on knowledge of the work to be done, experience in that work, appreciation of its need and value, confidence in one's own ability, pleasure and satisfaction in doing the work. If a nursing administrator and her nursing assistants are to develop good service, even in a practical nurse, they themselves must have a sympathetic understanding of the principles of hospital administrative practices and related problems, personnel policies and personnel counselling, ward administration and supervision, housekeeping, etc. Never has there been a greater need in hospital, medical, and nursing circles for unity, understanding, co-operation, and confidence in one another.

The head of the nursing service must have the confidence, respect, support, sympathy, and complete understanding of the superintendent of the hospital and the board of trustees, if she is to develop an effective and harmonious nursing service for the hospital. She should always be able to go to them for guidance and leadership. Likewise, she should be able to give guidance and leadership. Personnel are lost in a maze of misunderstanding and quibbling unless definite policies of employment, hours of work, vacation, sick time, promotion, standards of work, definition of jobs, responsibilities, etc., are set up. So, too, are they confused and uncertain unless someone takes time to carefully teach each worker what he is supposed to do and how he should do it. We cannot hope to have good personnel relations, understanding of nursing service policies, continuity of standards of service, without taking time to teach and explain to each new employee. All people who work in the hospital — from the head nurse to the cleaning woman — must be educated in one form or another.

You will say that this is impossible

with our present rapid turnover. Where hospitals have their policies and procedures written down, where workers can refer to them in their spare moments, you will find that it will help to maintain continuity of service with fewer breaks.

If we want to keep our people, we must have conveniences in the hospital for them. We cannot expect to keep even the ward maid to work a broken shift or report for duty at 7:30 a.m. with two and one-half hours off in the afternoon and report off at 7 p.m., unless we can provide satisfactory dressing- and rest-rooms, dining-room service and reasonable hours of work. We must be interested in their ills, their family problems, and work handicaps, their home surroundings and see that they get some satisfactions from life. To sum up, nursing service must have qualified leadership. Nursing care will always have to be administered by qualified people. Most of the non-nursing duties of nursing service can be done by a less highly skilled worker. This person should be licensed and limited in her duties.

Nursing service manuals would be a great help in stabilizing service and assuring continuity. Every worker must be taught her job. As long as hospitals depend too greatly on student service, they will not be able to devote themselves wholly to the purpose for which they exist — the care of the patient.

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Congress Plans

Plans are now proceeding for the next I.C.N. Congress which will be held in Sweden with headquarters in Stockholm. In order that the nurses will have as much time as possible to make satisfactory arrangements the president, Miss Gerda Höjer, announces that the Congress will commence either on **June 5 or June 12, 1949,** depending on the final decision of the Arrangements Committee.

As previously, there will be services in a number of prominent churches on the morning of the opening day. Registration will take place during the afternoon and will be followed in the evening by some form of suitable entertainment. Monday to Friday will be Congress days with carefully planned programs of interest to the nurses, with special emphasis on the present problems of the day. Some of these sessions will be held in various localities adjacent to Stockholm which will afford opportunities of seeing the Swedish countryside.

A general plan for group travelling is recognized to be of advantage and, therefore this method of travel will be followed during the Congress. The Swedish nurses have many treats in store for the nurses of the world and we have been assured that high on the list will be ample opportunities to view the Midnight Sun in midsummer. Further details will be published at regular intervals as plans develop. It is hoped that many nurses will plan to attend the Congress in 1949 and at the same time see Sweden and enjoy the Venice of the North.

Members of the profession who wish to be assured of comfortable accommodation should place their requests at the earliest moment. For the 1947 Congress, the efficient service provided by Travel Arrangements, under the direction of Miss Kathleen Tuite, was useful in bringing nurses from many countries to Atlantic City. The I.C.N. will be pleased to give further advice in regard to travel to those nurses who plan to attend the 1949 Congress in Sweden.

When a woman is angry, resentful or frightened, her stomach turns pale, slows down and produces less acid and gastric juices. A man's stomach behaves exactly the opposite. This may help to explain why stomach ulcers afflict four times as many men as women.

— *Science News Letter*

PUBLIC HEALTH NURSING

Contributed by the Committee on Public Health Nursing of the Canadian Nurses' Association

Volunteers in Child Health Conferences

ELIZABETH HACKETT

As a matter of common practice, especially during the stress of war years, many organizations, varied in type and purpose, find the assistance of workers other than those who are fully qualified most valuable in helping to maintain the continuity of service. These workers, whom we shall define for purposes of identification as lay workers or volunteers, are used for the less technical duties, thus releasing the trained worker for the more skilled tasks. Public health organizations in particular have frequent call for such workers. In a voluntary health agency which sponsored a baby clinic, we had valuable experience with this type of worker.

Sources: Volunteers may be obtained by various means. Perhaps one of our best sources is the governing board of the organization where individual members often show special interest in the work required. The Junior League, whose program has been prepared for such needs, has long been a most dependable and willing contributor when contacted for volunteers. Service clubs, like the I.O.D.E. and Women's Institute, can be approached for assistance. Other women's groups such as church clubs, community leagues, etc., may be canvassed for recruits. Then there are those persons not connected with any group who are chosen for their active interest and aptitudes for the task assigned.

Qualifications and requirements: It is important with the volunteer, as with the staff nurse, that a genuine interest in the work be present. Lack of interest and difficult adjustment are a general hindrance. Reliability and punctuality also must be considered for efficiency.

Neatness and pleasant appearance, as in all daily routines, add considerably to smooth functioning and create an impression that has its own value and attraction. It is recommended that the worker be attired in such a way as to distinguish her from the professional staff, yet fit her into the general schemes: wearing a colored smock will probably have this effect.

Where possible it may be advisable to ensure that the proposed worker is purely non-professional, that is, that she is not a registered nurse, or similarly trained person. By so doing the nurse in charge of the clinic will be spared interference based on comparative experience, and the attending mothers will be offered a definite program unmarred by confusing issues. In this latter respect we learned that full co-operation is essential. The volunteer should be aware that the nurse is in charge of the clinic, and should be familiar with both her own and the nurse's duties in the functioning whole. Here it is that a well-prepared training plan for volunteers is seen to be important.

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Preparation of volunteers: The service of the volunteer worker should be encouraged and fostered. It should be realized that such lay participation increases the usefulness of the public health nurse herself if the worker is well instructed, guided, and supervised by the professional worker. The proper preparation of volunteers will include an initial personal interview with the professional worker in charge before the volunteer begins her duties. The physical set-up of the total organization is explained; the functions of the board; how finances are raised for the organization; the policies of the organization and the functions that the agency performs as one co-operating unit in the community health program are some of the topics about which the worker will need knowledge.

The more detailed duties of that particular volunteer are then explained and discussed. The unit where the services are to be performed is visited and demonstrations given as required. A printed list of duties is helpful. The worker is assisted with her duties until she becomes thoroughly familiar with them. The nurse and lay worker each realize that they are working together for the maintenance of standards, through the better interpretation of the need for health work in the community. The worker can function efficiently, safely, and be most valuable only with the guidance and general supervision of the professional worker. Each worker volunteering her services to a health agency should be treated as a partner with well-defined duties to perform and with a thorough understanding of the functions of that agency.

Duties: Ideally, we like to think of our volunteer worker functioning with the efficiency of a social secretary. It is she who greets the mothers (old and new) assigning each to seats and available tables. Securing their names, she can locate the records of babies who have attended previously and, for those new to the clinic, she can obtain the required record information and instruct the mother in the clinic routine preparatory to discussion with the nurse. She will also bring urgent cases to the nurse's attention.

Becoming familiar with the use of the scales, the volunteer can weigh the babies and mark their weight cards, recording the weights along with date and age on the clinic form. These forms with attached weight cards are placed on the desk in order of entry thus awaiting further use by the nurse as she instructs each in turn. The volunteer in the meantime sees that the undressing tables and the scales are kept clean and changed, and that attendance statistics are kept for official use. It may also be suggested that the volunteer be responsible for the setting up and clearing away of clinic equipment thereby allowing the nurse an hour extra in the district.

Summary: With such a program the volunteer is a definite asset. Health education being the aim of the well-baby clinic, the nurse can concentrate upon instruction if a voluntary worker is present to fulfil the other functions required in operation. For organizations operating on a limited budget, with a minimum of staff workers, the use of volunteers offers a saving of time and energy and an opportunity to divert the skilled personnel to assignments requiring their special qualifications. Further, beyond the material benefit is the interpretative value which the lay worker can so often take to the community. When based on a pleasant co-operation the attendant publicity may be most beneficial.

Too often professional groups tend to work alone, excluding the outsiders because they may lack complete understanding, forgetting that, as in life itself, shared interests and responsibilities bring a greater reward and fulfilment. Indeed, if we look back into past ages we will find as an historical fact that, the progress of civilization and development of humanitarian rights have not infrequently been spurred by the zeal of those who voluntarily gave of their abilities and services to further some cause.

INSTITUTIONAL NURSING

Contributed by the Committee on Institutional Nursing of the Canadian Nurses' Association

Living and Working Conditions for Professional Personnel in Hospitals

Margaret M. Street

A sub-committee of the Committee on Institutional Nursing of the Association of Nurses of the Province of Quebec was appointed in March, 1947, for the purpose of studying the question of living and working conditions for various categories of professional nursing personnel engaged in institutional work. The project was undertaken at the request of the Committee on Institutional Nursing of the Canadian Nurses' Association which had initiated a Dominion-wide study of personnel policies and procedures in relation to nursing staffs in hospitals.

The personnel of the sub-committee was fairly representative of the various categories of nursing personnel, although no general staff nurse had been included. However, all of the members were in close touch with general staff nurses, and this fact was a great asset in the study which was made.

This topic is, of course, of tremendous scope. It is so closely related to personnel policies and practices generally that it was found difficult to avoid entirely certain aspects of the whole question which had been assigned to other provinces. Another difficulty was encountered in the attempt to set up standards which could be applied in all situations. The sub-committee decided, therefore, to limit itself to a consideration of certain broad general principles. For study purposes, the topic was divided into the following aspects: (a) Agreement upon employment; (b) vacations and other absences; (c) maintenance of personnel; (d) hours of duty; (e) health program; (f) care during illness; (g) working facilities available for the nursing service; (h) ward manuals; (i) the relationship of the sub-staff to a smoothly-functioning nursing service; (j) the staff association; (k) the private duty nurse in hospitals.

Each member assumed responsibility for one of the above questions, and each brought a report of her study to the whole sub-committee for discussion. The convener then summarized the findings and prepared this article.

Agreement Upon Employment

The personal interview between the superintendent of nurses and the prospective nurse employee is of great importance. Good employment relationships between the nurse and the institution may well have their roots in a clear understanding regarding conditions of employment, living and working conditions. The duties and responsibilities of the

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position, hours of duty, salary, opportunities for promotion, opportunities for rotation through various services, if desired; policies regarding holidays, sick leave, and hospitalization; living accommodation within or outside the institution; arrangements regarding meals and laundry; health program; staff education program; recreational facilities and cultural opportunities available in the institution and in the community; rest rooms available for staff living out — all these should be discussed with the prospective staff member.

The terms of the agreement should be in writing. A contract should be signed; and the length of notice to be given by either party to the contract (e.g., twenty-eight days) should be stated specifically.

It would be an excellent procedure to provide mimeographed copies of the personnel policies and practices of the institution for all new members of the nursing staff. Mimeographed sheets would be preferable to printed booklets in that the former would lend themselves more readily to revision.

A feeling of belonging should be created in the nurse at the very outset. Her orientation to her duties should be carried on with thoroughness in the ward or department to which she is assigned. The kindness and courtesy shown to the new staff member in assisting her to become familiar with all aspects of the institution's life — e.g., location of the dining-room and her place in it — will reap rich dividends in the peace of mind and contentment of the new staff nurse.

VACATIONS AND OTHER ABSENCES

If employment is permanent, a nurse could expect to have one month vacation after one year of service. After six months of service, she should have the right to a proportional vacation.

In any plan, vacations should be given for services rendered and salary paid to include vacation due, should the agreement between the employer and the nurse be terminated.

Statutory holidays — viz., New Year's, Dominion Day, Labor Day, Thanksgiving, Good Friday, Victoria Day, and Christmas — should be recognized as holidays. Not all nurses could be off duty at one time, naturally, but arrangements should be made for each to have a day not too far distant from the statutory holiday.

In the case of a death in the nurse's immediate family an absence of four days, without loss of pay, should be allowed.

A nurse should be granted leave of absence for post-graduate study providing her services have been satisfactory.

If the institution desires to have the nurse prepare for a particular position, requiring post-graduate preparation, it is reasonable to expect that the nurse will be granted leave of absence with the expenses of the course fully paid.

As a development for the future — and one which might well lead to greater stability of staffs in hospitals — it is suggested that for nurses who have been employed by an institution over a long term, seven years or more, a sabbatical year could be arranged, with the proviso that the nurse return afterwards to the institution for a period agreed upon.

Leave of absence, with salary, to attend professional meetings is recommended. In the case of the director, her assistants, or a nurse appointed by the director, a reasonable expense allowance should be made.

Sick leave pay for a definite period is recommended — e.g., two weeks each year.

MAINTENANCE OF PROFESSIONAL PERSONNEL

A. *Living conditions for graduate staff living in residence:* It is recommended that the residence be separate from the hospital, but that it be connected by underground tunnel to allow for protection against rainy and winter weather. The building should be fire-resistant, appearance attractive, grounds well-kept. There should be two or more residence supervisors, carefully chosen, preferably registered nurses. It is recommended that the living accommodation be so arranged that supervisors, general staff nurses, and students live in different parts of the building so that each group may enjoy her own age group. It is recommended that the following be provided:

Large reception rooms for social gatherings, and smaller reception rooms for individual or smaller parties, all rooms attractively furnished; library and reading-room with current professional magazines and newspapers; recreation room for indoor sports; tennis court and swimming pool if space allows, otherwise arrangements so that the nurse may enjoy the privileges of the local "Y" or other association providing these facilities; a screened porch or privately located veranda to allow for sun-bathing; public telephone in booth.

Receptionist to ensure that mail and messages are received and delivered promptly, and to admit and direct callers; a cloakroom and washroom for gentlemen visitors; good standards of upkeep and housekeeping; adequate supply of linen; a kitchenette on each floor; sufficient food for breakfast or light lunches available; fresh milk and fruit juices in the refrigerator at all times.

A small laundry room for the nurse to do her personal laundry; uniforms to be called for, laundered, and returned by the hospital.

Good storage space for trunks, skis, and other bulky sports equipment. Tubs, showers, wash-basins, and toilets in a ratio of one to each of six nurses. Abundance of hot water.

Dining-room to be well lighted and to have attractive appointments. Meals to be well balanced, varied, food carefully selected, properly prepared and appetizingly served.

Single bedrooms, well ventilated, heated and lighted, with wall sockets for reading-lamps. Comfortable bed, wardrobe, desk, dresser, easy chair, and hand-basin with hot and cold water in each room. Suite of rooms for the director of nursing; senior supervisors to share suites. Quiet, isolated wing for the night staff. Arrangements for care in residence if mildly ill.

Facilities for morning coffee and afternoon tea.

B. *Living arrangements for graduate staff living out:* The following are recommended:

Substantial living-out allowance, according to cost of living in that area.

Laundering of uniforms to be provided by the hospital.

Dining-room, meals, and facilities for morning coffee and afternoon tea similar to that provided for those living in residence. Rest rooms and reading-rooms for special use of nurses living out.

Public telephone in booth near the locker-room. Locker-room to be well ventilated, heated, and lighted; individual metal lockers with lock and key; sufficient number of benches, chairs, mirrors, and dressing-tables; a couch; a washroom in connection with the locker-room containing adequate hand-basins, toilets, and one or two showers.

HOURS OF DUTY

This topic was assigned to another province for detailed study. However, our sub-committee decided that some thought should be given to the question of hours of duty inasmuch as these have such an important bearing on working conditions for nurses in institutions. In brief, the conclusions reached by the sub-committee were as follows:

(a) Although at the present time an eight-hour day and a six-day week are standard practices, thought is being given to the desirability of a 44-hour or a 40-hour week for hospital staff nurses.

(b) Hours of duty should be consecutive as far as possible.

(c) Further study should be given to the question of hours of duty for head nurses and for their assistants. Head nurse groups in hospitals might be asked for an expression of opinion on this matter. In certain situations, head nurses have asked that broken hours of duty be continued, in preference to straight hours. The sub-committee reached no definite conclusion regarding this.

(d) There was considerable discussion regarding hours of duty for classroom instructors. Again no definite conclusion was reached. One suggestion was advanced that classroom instructors, who inevitably spend many of their leisure hours planning work, marking papers, etc., should have every week-end off duty, just as teachers do in other spheres. It seems necessary to provide more attractive conditions generally for instructors if nurses are to be interested in entering this specialty.

(e) For general staff nurses, an eight-hour day and a six-day week, with systematic rotation through afternoon and evening duty, are recommended.

(f) All hours of duty should be posted one week in advance, so that nurses may plan off-duty time.

(g) There was some discussion regarding the advisability of rotating clinical supervisors through day, afternoon, and night periods of duty, in preference to having a permanent staff of night supervisors. No conclusion was reached.

Health Program and Care During Illness

A. *Prior to employment:* A general physical examination by a doctor on the staff of the hospital — weight, x-ray of chest, blood Wassermann, hemoglobin estimation, Mantoux test I: 1,000, urinalysis.

B. *Annually:* General physical examination. Hemoglobin estimation. X-ray of chest.

C. *Mantoux Test I: 1,000:* Repeated every 3-6 months, if negative.

Health services should be provided with confidential records kept for all graduate personnel. Staff nurses should have the doctor of their own choice. Special tests and examinations as required. Medications at cost price or with special discount. Provision should be made for graduate staff who live out to be cared for in the residence or infirmary — hospitalized if necessary.

Time allowed for illness: Policy should be defined by each institution in this regard — e.g., two weeks after one year of service. Time allowance should be commensurate with length of service. If x-ray of teeth is ordered, nurse should pay cost of film. Physiotherapy, massage, short wave, quartz lamp provided at special rates or free.

It was the feeling of the subcommittee that every staff nurse should have hospitalization insurance, and also insurance covering medical and surgical services.

Working Facilities

The convenience of well-planned service facilities, and the ready availability of supplies and equipment, have a direct relationship to an efficient and contented nursing staff. It is now generally recognized that central supply rooms are almost indispensable to modern, swiftly-paced nursing service. Central dressing-rooms have been established in some hospitals, also, and have proved most valuable adjuncts to the nursing service. Good service facilities assume added importance as time and energy-savers when nursing staffs are depleted in numbers. They are invaluable also to the medical staffs of hospitals.

Ward Manuals

Good ward manuals, containing standing orders and routines peculiar to the hospital and to the departments, are aids to efficient nursing and contribute much to making working conditions attractive. Such manuals must be well thought out to be of value. They may contain outlines of job analyses for all staff members, so that the duties to be undertaken may be well understood.

The Hospital Sub-staff

It is recognized that the quantity and quality of the hospital sub-staff are vital factors in helping to promote smooth functioning of the nursing service. An adequate number of well-trained and supervised workers on the sub-staff will free the nurses for undivided attention to their nursing duties. As a result, patients will be better nursed, and the nurses will derive much greater satisfaction from their work because they will have time in which to give quality nursing care.

In order to attract and hold sufficient sub-staff of good calibre, it is necessary that conditions of employment, salaries, hours of duty, personnel policies, etc., compare favorably with those offered by industrial firms. It has always been difficult for hospitals to compete with other employing agencies because of more limited financial resources. Yet hospitals are rendering indispensable community service, which deserves to be recognized and financed by the public in whose interests these services are being carried out.

Hospital non-nursing personnel, in order to function effectively in their various duties, should be given thorough instructions in their duties before they undertake them. Instruction, orientation, and supervision are essentials governing employment of practically all categories of workers in industrial occupations. The principles of preparing the worker for his job and giving him constructive guidance, and supervision in it are of, at least, equal importance in hospitals where all workers are directly or indirectly engaged in occupations which have a bearing on the care and welfare of the sick. Should thought be given to establishing instruction centres for various categories of hospital non-nursing personnel? The instruction of orderlies should be carried out by qualified nurse teachers. It would be of immeasurable benefit to the institution if the orderlies were to come to the hospital with a basic training given at a recognized and approved centre. Further instruction and orientation, as well as supervision, would of course be given by the hospital.

Nurses' aides may be instructed by nurse instructors in the employing hospital. They may assume many duties which will release nursing service time for the care of the sick: dusting, care of flowers, refilling water pitchers, running errands, listing clothes and valuables, answering lights to ascertain patients' needs, tidying cupboards, cleaning equipment, making empty beds. They may assist also with simple nursing duties, such as washing patients' faces and hands, filling ice collars, etc. The instruction and supervision of these workers are essential.

Receptionists on the wards perform many duties of a non-nursing nature which otherwise consume many hours daily of nursing time: answering the telephone, taking messages for doctors and patients, making out the ward slips, receiving and directing visitors.

Ward aides perform some of the duties which may be done by nurses' aides, but none which include simple nursing duties. By releasing the nurses from such duties as dusting, care of flowers, etc., they are of great assistance in hospitals.

Maids and cleaners require careful instruction and supervision for their own protection and for that of the hospital, the patients, and all other personnel.

THE STAFF ASSOCIATION

The organization of a staff nurses' association forms an excellent basis for mutual understanding, co-operation, and staff education, as well as for direction in social activities, especially for a staff composed of graduates from different schools.

The association should have a constitution, the usual officers and conveners, and a fee which would cover such expenditures as gifts to resigning members, flowers, etc. However, the fee should not take care of donations to charitable organizations, which should be considered the responsibility of the individual.

Regular meetings to discuss current problems should be held in on-duty time.

The convener of the educational committee should be responsible for arranging programs of general interest, such as an outline of the course taught to students, newer drugs and treatments, films of interest, and speakers from other professional groups.

The social convener will take care of all group social activities.

THE PRIVATE DUTY NURSE

The place and function of the private duty nurse in hospitals should be examined carefully and re-defined. The private duty nurse is actually a specialist in bedside nursing. Her duties comprise the care of the patient. She is under the supervision of head nurse and supervisors, who, acting for the hospitals, are jointly responsible for the patient's care and welfare while in the institution.

Too frequently, the private duty nurse is left too much to her own resources, however. She does not feel that she is an integral part of the total ward situation; she may even feel that she is an outsider on the ward, and that her patient is not considered the responsibility of the hospital nursing staff or of the dietary staff. This misapprehension is most regrettable when it arises and should be cleared, or better still, should not be allowed to arise.

The private duty nurse in hospital complains, too, that there is frequently no place for her to leave her clothes, no lockers available. She finds it an additional hardship when no restroom, or an inadequately-equipped restroom, is provided for her use.

Another difficulty encountered by the private duty nurse caring for a patient in hospital is the difficulty in procuring needed supplies and equipment. She complains that she wastes much time in the pursuit of keys. The private duty nurse, coming for the first time to a strange hospital, may not be given the assistance she requires. Busy ward nurses may appear to be unfriendly or indifferent. The following are recommended as measures which would improve living and working conditions for private duty nurses in hospitals:

1. Provision of well-ventilated locker-rooms, adequately lighted and heated, provided with individual metal lockers with lock and key; sufficient number of benches, chairs, mirrors, and dressing-tables; and a washroom with hand-basins, toilets, and showers.

2. Centralization of supplies and equipment so that these would be available with the minimum of delay.

3. Orientation of outside graduates to the institution and to the ward.

4. Recognition by all nursing staff personnel of their responsibility toward the patient with a private duty nurse.

5. Recognition by all nursing staff personnel of the prestige of the private duty nurse.

6. Further study of the question of the problems of the private duty nurse, and an effort to promote clearer understanding and more goodwill between the private duty nurse and hospital staffs.

From the point of view of hospitals, it would be desirable if the vacation periods of private duty nurses could be so arranged that there would be adequate numbers of private duty nurses available for all times of the year. It would also be very much appreciated if there could be more adequate coverage of nurses for the 3:30-11:30 p.m. period of duty.

In presenting the above report, the sub-committee wishes to acknowledge valuable assistance received from the following material:

"Manual of Essentials of Good Hospital Service." N.L.N.E. and A.H.A., 1942.

"American Nurses' Association Recommendations — Based on National Findings, Having Implications for Nurses Engaged in Institution-Nursing Service." 1938.

"Staffing the Hospitals — An Urgent National Need." Minister of Health, Great Britain, 1945.

Recommendations Regarding Personnel Practices of the Registered Nurses' Association of British Columbia. 1946.

California State Nurses' Association — Schedule of Employment and Standards for Institutional Staff Nurses. 1945.

"Personnel Policies for Public Health Agencies." N.O.P.H.N., 1946.

National Health Week

Canada's fourth annual "National Health Week" will be observed during the first week in February — February 1-7 — it is announced by Dr. J. Z. Gillies, chairman of the Health Week Committee of the Health League of Canada. In announcing the dates of this annual event, which is sponsored by the Health League in co-operation with official departments of health and education throughout Canada, Dr. Gillies explained that its purpose is to draw attention of all Canadians to the benefits of good health and the appalling costs of sickness and untimely death. One theme for the observance will be the challenge — "Guard Your Health — Know How!"

Health Education

One of the most important functions of the public health nurse in a school health program is to stimulate other school personnel in the initiation and development of certain projects in health education which will fill the particular need of the moment. Her responsibility in planning and preparing for routine health procedures puts her in a strategic position to know the proper time for presenting certain health information to the children and, after consultation with principal and teachers, to help decide on the most interesting and suitable method of presentation.

— Edna Coldren, R.N.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

Les Problèmes de la Vieillesse

EVARISTE CHOQUETTE

Monsieur Evariste Choquette, né à Ottawa, est un diplômé de l'Université de Montréal en Sciences Sociales. Il étudia à l'Université d'Yale les problèmes des alcooliques.

Durant douze ans il s'occupa des mouvements de Jeunesse et du Bien-Être familial. Il contribua à l'organisation de "La Réhabilitation Sociale des Hommes," société qui a pour but de venir en aide aux prisonniers. Actuellement Monsieur Choquette est assistant-directeur au conseil français des oeuvres sociales; c'est à ce titre qu'il organisa des journées d'études pour les directeurs de maisons pour vieillards, celà le conduisit à faire des recherches poussées dans ce domaine.

Nous regrettons d'avoir eu à abréger l'article de Monsieur Choquette. Les infirmières qui ont eu le plaisir de l'entendre lors de la conférence régionale de la Métropolitan Life Ins. Co. penseront, comme moi, que si intéressant, si instructif que soit l'article de Monsieur Choquette, rien ne peut remplacer la chaleur, la conviction de l'apôtre lorsqu'il parle de ses chers vieillards.

—SUZANNE GIROUX

Au cours de cette journée, vous avez entendu de brillants exposés sur certains problèmes de la vieillesse. Vous avez étudié la situation des vieillards aux points de vue médical, psychologique, familial et hygiénique.

En plus de ces différents aspects, il existe pour beaucoup de personnes âgées des problèmes connexes dans les domaines économique et social. Par vos études antérieures, vous vous êtes sans doute rendu compte que les personnes âgées se divisent en plusieurs catégories. Nous pouvons en compter au moins cinq dont la première est constituée d'individus capables d'activités presque sans limite, qui n'ont besoin d'aucune surveillance et qui peuvent voyager dans la ville sans danger.

La deuxième comprend les individus capables d'activités modérées, qui peuvent se débrouiller seuls dans le voisinage du foyer, mais qu'on doit escorter lorsqu'ils ont à faire un voyage le moindrement long et tant soit peu fatigant.

La troisième catégorie comprend les gens dont les capacités sont limitées et qui nécessitent une assistance et une surveillance constantes dans les activités qu'ils entreprennent. On doit toujours les accompagner sur la rue. En somme, ils sont pratiquement confinés au foyer.

La quatrième catégorie groupe les personnes qui sont retenues au lit ou à l'entourage de celui-ci.

Enfin, il reste ceux qui sont totalement aveugles ou dont la vue est à un tel point affectée qu'ils ne peuvent plus prendre soin d'eux-mêmes.

La vieillesse n'est pas un phénomène qui se produit subitement. C'est un état progressif qui trahit les stigmates que le temps a imprimés sur l'individu.

On devient ce que l'on est par suite de l'hérédité, à laquelle s'ajoute une suite d'expériences personnelles. A la lumière de ces expériences nous avons façonné notre manière de vivre. La courbe de notre vie active monte tant qu'on peut se suffire à soi-même et être utile à la société. Cette courbe se stabilise lorsque notre apport physique et mental ne peut plus être une contribution dans la collectivité où nous vivons. Ensuite, elle décroît graduellement, à mesure que nous avons besoin de l'assistance de nos semblables pour nous aider à continuer notre route.

Le vieillard redevient comme l'enfant à qui on a dû apprendre à marcher et à éviter les écueils, sauf que pour lui l'habileté physique et mentale rétrograde. Cette rétrogradation varie selon les conditions physiques (la maladie et l'usure) et mentales (la culture et les épreuves); mais elle est quand même la courbe descendante de l'activité humaine. Lorsque nous pratiquons l'assistance auprès des vieilles gens, nous devons nous rappeler que s'ils rétrogradent, ils ont tout de même déjà connu l'expérience de la vie. Pour chaque individu, il nous faut chercher à comprendre sa mentalité, ses antécédents; et s'efforcer de se substituer à sa personne pour analyser ce qu'il pense, ce qu'il désire, et comprendre avec lui ce qu'il lui faut pour le rendre heureux.

La nécessité de l'attention individuelle existe autant pour les personnes âgées que pour n'importe quel autre groupe d'individus. On ne peut pratiquer cette forme d'assistance d'une manière collective et efficace à la fois, pas plus qu'on ne peut élever des enfants selon une méthode stéréotypée.

Les vieillards ont donc besoin d'attention personnelle parce qu'on ne traite pas avec des personnes de différents âges et de différentes cultures de la même façon dont on peut le faire avec des groupes homogènes.

Au point de vue psychologique, personne n'admet qu'il vieillit et n'aime à être traité en vieux. A mesure que les années avancent, nous sommes plus intéressés à prouver que nous sommes encore bons.

Cependant, lorsqu'arrive l'âge de 45 ans, nous remarquons que quantité de gens ne peuvent plus être embauchés. La coutume s'est établie ainsi, dans le monde du travail, en s'appuyant sur une prétendue diminution des capacités d'ajustement. Pourtant, des enquêtes ont prouvé que les accidents de travail sont moins fréquents chez les 45 ans valides que chez les plus jeunes et plus téméraires. Même que celui qui a déjà eu un accident de travail répète rarement parce qu'il est devenu plus prudent. De plus, les fonds de pension de vieillesse et certaines assurances ont fixé l'âge de la retraite à 65 ans.

Ajoutez à ces deux facteurs celui de la durée de la vie qui augmente sans cesse et vous comprendrez facilement que le nombre de personnes âgées préoccupe de plus en plus les sociologues qui s'intéressent à ce qui est en voie de devenir un problème sérieux.

Depuis 1891, date du premier recensement fédéral, le nombre des personnes au-dessus de l'âge de 45 ans, est monté de 16 à 20 pour cent en 1941. Il y a 50 ans, on ne vivait en moyenne que jusqu'à l'âge de 44 ans, et aujourd'hui cette moyenne dépasse 60 ans. Pour cette population flottante, la société n'est pas pourvue de système qui permette l'exploitation d'autant de ressources humaines. Cependant, ceux qui ont le devoir de penser à l'avenir, doivent organiser la vie de ces gens pour qu'elle leur soit moins lourde, sinon productive.

Tant que les personnes qui ne peuvent plus être embauchées, ou celles qui doivent prendre leur retraite sont dans la première des catégories que je vous ai définies tantôt, il n'y a pas de sérieux problème économique. On doit cependant se poser la question, à savoir: si ces personnes n'ont pas elles-mêmes de graves problèmes économiques et si elles peuvent encore participer aux activités collectives dans toute la mesure de leur ressource?

A cela, je réponds non, parce que la collectivité les a classifiées, d'après une base arbitraire, en s'appuyant sur l'âge qui ne peut être un indice commun.

Les années n'ont pas exercé pour chacun les mêmes ravages. Certains peuvent être vieux à 45 ans, alors que d'autres pourront donner un excellent rendement encore à l'âge de 65. Au point de vue économique, la société perd donc le fruit de belles ressources chaque fois qu'elle met de côté l'expérience acquise pendant de longues années par un homme encore en état de produire.

Si les économistes du travail jugent cet actif comme quantité négligeable, ils doivent se rendre compte qu'en ce faisant, ils contribuent à la naissance d'un problème social.

Ici, je fais remarquer que les Chinois ont une très belle conception de l'expérience et apprécient la sagesse acquise avec l'âge. Les anciens sont vénérés dans tous les milieux précisément parce qu'ils ont vécu longtemps et qu'ils peuvent apporter un concours irremplaçable par leurs conseils sinon par leur bras. Le matérialisme économique, l'ambition de la production intense et rapide n'a pas engourdi leur coeur et leur intelligence. Ils témoignent encore de la considération à ceux qui peuvent leur être infiniment utiles en guidant les pas des moins expérimentés.

Chez nous, lorsque quelqu'un d'un certain âge est couvert de la couronne de lauriers pour ses longs états de service, il n'a plus qu'à s'en aller chez lui, s'asseoir au coin du feu, regarder faire la popotte et prodiguer des conseils qui ne sont pas toujours bienvenus dans ce milieu qui n'est pas véritablement le sien. Son milieu à lui, c'était le milieu de travail où il avait passé plus d'un tiers de sa vie. Les deux autres tiers furent passés en sommeil et loisirs. Qu'il revienne auprès de son épouse ou chez ses enfants, ce n'est pas là qu'il a été habitué de passer les heures ensoleillées du jour. Il sera tenté de montrer comment faire la soupe ou comment élever les petits enfants. En agissant ainsi et sans toujours s'en rendre compte, il deviendra de trop. Il le réalisera le jour où la remarque lui sera faite "qu'il a joué son rôle quand c'était le temps" et que "c'est maintenant au tour des autres." Alors que fera-t-il, lui qui se sent encore bien l'envie de vivre et qui sait pouvoir encore être utile? En fait, il pourrait l'être, mais dans la chose pour laquelle il a été entraîné, et là, on l'a mis au rancart pour une raison bête de calendrier.

Ce problème social se développe parce que la situation a créé un individu malajusté, par conséquent, malheureux. Que pouvons-nous faire pour l'aider dans sa vie nouvelle de pensionnaire ou de rentier? Nous n'avons pas grand'chose à lui offrir. Il versera des larmes dans le secret de la chambre et bientôt nous serons témoins d'une santé qui se mine rapidement. Il deviendra un égocentrique donnant le spectacle d'un véritable vieillard affligé des mille petits bobos de tous les jours et dont le principal est l'ennui dégénéré en neurasthénie. Un tel comportement, si on n'y apporte de remède par une thérapeutique efficace, rendra la situation incompatible avec la vie du ménage qui abrite cette personne âgée.

Après s'être accommodé tant qu'on aura pu d'une situation anormale, après s'être prêté généreusement pour concilier les choses, après avoir exploité la vertu de charité filiale; on sera souvent en face d'un problème comme celui du logement trop exigu, de l'hygiène compliquée par la présence d'une vieille personne, de l'économie compromise parce que cette personne requiert maintenant des soins onéreux que le budget de la petite famille ne peut plus supporter à cause de l'augmentation du coût de la vie et aussi des complications qu'apporte la présence d'un parent quand il s'agit d'élever ses propres enfants.

Et voici précisément une question de justice qui se pose. Doit-on ou ne doit-on pas garder les vieillards avec nous? Quand? Pendant combien de temps? Dans quelles conditions? Avons-nous le devoir de les garder, ou avons-nous le devoir de veiller à notre responsabilité immédiate, lorsque le sort des enfants est en jeu?

La première solution qui vient à notre esprit, lorsque nous sommes en face d'un tel problème, est le rêve d'une maison où ces chers vieux seraient installés dans des conditions correspondant à leurs besoins. Des vieillards, comme des enfants, on peut dire qu'ils ont besoin d'un milieu adapté à leur évolution physique et mentale; en un mot on ne peut prétendre créer des conditions de vie universelles qui soient propices à des enfants en même temps qu'à des personnes âgées. Les deux cas représentent chacun des extrêmes. L'atmosphère d'un milieu ne peut pas du tout, même avec la meilleure volonté du monde, et avec les plus belles ressources matérielles, convenir également aux deux groupes. L'enfant et le vieillard ne peuvent pas être indéfiniment heureux en vivant conjointement dans le même petit vivoir ou la même cuisine. Si l'aisance permet un logis plus spacieux, on pourra tenter une solution en aménageant des pièces spéciales pour chacun. D'autre part, nous ne vivons pas dans un pays de rêve et personne n'ignore, aujourd'hui, que la crise du logement a grandement empiré les choses. On verra une personne âgée coucher dans le même lit qu'un enfant ou un adolescent. En dehors des heures de sommeil, le logis n'offre aucun espace pour le repos ou les loisirs de l'un ou de l'autre. Au point de vue hygiène, la situation s'aggrave. Les conséquences de la sénilité du vieillard s'étalent aux yeux de tous, et les enfants sont témoins de spectacles déprimants. Les gardiens de personnes âgées, après avoir longtemps réfléchi et hésité, en viennent à conclure qu'il faut placer les vieux et se résignent enfin à entreprendre les démarches.

C'est à ce moment que commence une longue série de déplacement, en quête d'un foyer ou d'un hospice qui aura une place pour la personne qu'on veut loger. On s'imagine que Montréal est largement pourvu d'hospices pour vieillards de toutes les catégories et de toutes les conditions.

Cependant, avec 18 hospices, contenant 1,915 lits, il est impossible de répondre à toutes les demandes qui se présentent.

Ces hospices qui, au début de la colonie, ont été fondés dans un but d'hospitalité ont toujours continué à héberger vieillards séniles, malades chroniques et orphelins sans distinction de conditions physiques ou matérielles du requérant, et ce, à chaque fois qu'on leur faisait une demande pour obtenir l'hospitalité.

Depuis la fondation de la première maison, par Mère Youville, fondatrice des Soeurs Grises ou Soeurs de la Charité de Montréal, la situation a beaucoup changé. Le premier hospice, qui n'était rien de plus qu'un département d'hôpital, réservé aux soins des vieillards et des enfants illégitimes, avait justement sa raison d'être, puisque aucune autre institution ne pouvait remplir cette double fonction. Seulement, depuis ce premier hospice, sont nés des hôpitaux, des crèches, et on a fondé des maisons spécialement affectées au logement des vieillards. Ce sont ces dernières qui ont conservé le nom d'hospice. Les crèches se sont multipliées et spécialisées dans leur travail propre, cependant que les hospices désormais réservés aux vieillards sont restés des maisons d'hospitalité, au sens large du mot.

Aujourd'hui, et d'une façon bien particulière depuis le début du siècle actuel, après que nous avons eu deux guerres et traversé une crise économique qui ont eu comme résultat presque immédiat l'urbanisation de la population dans un centre industriel; nous ne devons pas être surpris de constater que les hospices de Montréal, quels que soient leur nombre et la qualité de leur service, sont bien loin de répondre aux besoins.

Il n'y a pas de jour où chacune des 18 maisons ne refuse trois ou quatre patients, faute de place.

Disons tout de suite, afin d'être juste vis-à-vis des religieuses, que nous savons, pour l'avoir constaté maintes fois, que lorsqu'elles refusent des nouveaux patients c'est réellement parce qu'il n'y a pas de place. Partout, la capacité des maisons est dépassée. Ce n'est qu'à force d'héroïsme et même de prodiges que les religieuses réussissent à maintenir une si grande population dans des maisons qui ne sont pas favorisées de toute l'aisance matérielle. Elles souhaitent plus que n'importe qui de pouvoir donner tout le confort possible à leurs vieux.

Toutes les maisons pour vieillards sont encombrées, qu'elles soient laïques ou religieuses, même les places pour pension dans les foyers privés sont rares. Admettons qu'en ce qui concerne ces dernières, c'est parce que l'état de santé du vieillard est incompatible avec les ressources d'un foyer ordinaire. Le problème se pose donc et on serait tenté de répondre vivement: "Fondons de nouveaux hospices, et le problème sera réglé!" Par contre, ceux qui ont étudié assez profondément la situation ne peuvent pas recommander cette solution. Cela n'est pas du tout un paradoxe.

Revoyons ensemble les faits révélés par cette enquête conduite par "l'American Association of Medical Social Workers," en collaboration avec la compagnie d'assurance Metropolitan. La recherche portait sur le soin des malades chroniques dans Montréal.

Elle révéla que 70 pour cent de la population des hospices était composé de ces malades, donc les 7/10 des gens qui sont là ne sont pas à l'endroit qui convient à leurs besoins.

Les hospices, tels que nous les connaissons, ne sont pas des hôpitaux. Ils sont des maisons pour vieillards, avec organisation de dortoirs, de réfectoires et un dispensaire destiné à secourir ceux et celles qui sont légèrement indisposés. Certaines pièces sont réservées pour les grands malades, les paralytiques, par exemple, ou les cardiaques; les malades de cette quatrième catégorie qui ne peuvent aller plus loin que leur lit.

Mais aucun hospice, à ma connaissance, n'est organisé pour pourvoir au traitement d'un aussi grand nombre de malades qui auraient bien plus besoin d'un hôpital spécialement organisé à cet effet, plutôt que d'un endroit de repos. Cette situation économico-sociale a contribué à répandre dans l'opinion des gens cette légende qui fait de l'hospice un endroit où on ne va que pour mourir. D'ailleurs, qui ne s'est pas rendu compte que dans le public, se diriger vers l'hospice c'est presque le déshonneur, ou pour le moins c'est dégradant. L'hospice est mal compris, et il ne s'agit pas de blâmer qui que ce soit pour un tel état de chose. Ceux et celles qui ont entretenu des hospices jusqu'à aujourd'hui, les ont développés dans un esprit de charité toujours et dans le but de rendre des services immédiats, de répondre aux besoins du jour, sans jamais les développer en fonction d'un programme conçu après l'étude de la situation sociale, des exigences présentes et futures.

A l'heure actuelle, lorsque nous voulons placer un vieillard dans une institution, nous éprouvons beaucoup de difficulté à obtenir une place. Les hospices sont surpeuplés de patients, représentant les catégories les plus diverses. Au moment de la demande d'entrée, si les patients sont atteints de maladies chroniques, ils sont refusés par l'hospice et ne peuvent que se diriger vers l'hôpital Notre-Dame-de-la-Merci, pour les hommes, et l'hôpital Notre-Dame-de-Lourdes, pour les femmes.

Ceux qui sont acceptés par l'hospice ne doivent pas être atteints de maladies chroniques au moment de leur acceptation. On abritera les malades qui n'exigent pas trop de soins médicaux et les personnes qui peuvent prendre soin d'elles-mêmes. Il est bien entendu que ces patients, étant des vieillards, développent des malaises croissant avec le progrès de leur sénilité. Le problème des hospices naît avec ce développement.

Les vieillards développent progressivement des maladies chroniques et parce qu'on n'a pas d'institutions spécialisées pour ces malades on doit continuer de les garder dans ce qui devrait être un foyer, une résidence pour vieillards. La situation ne serait pas si grave si elle n'était cousue de problèmes dérivant de cet état de chose. Si l'hospice devait demeurer un hôpital dont la majeure partie des patients seraient des grands malades, nous n'aurions qu'à en changer l'étiquette pour celle d'hôpital pour malades chroniques, aménager cet hospice de façon à lui permettre de remplir son rôle d'hôpital et le problème serait à peu près réglé. Malheureusement, il n'en est pas ainsi. Les maisons qui prennent soin des malades chroniques ne sont pas aménagées pour en prendre soin dans une telle proportion. Nulle part, on fait de classifications autres que celle qui s'impose péremptoirement par l'état de santé et même à ce point de vue, la classification médicale est bien sommaire. Les autres, représentant 30 pour cent de la population, ceux pour lesquels l'institution existe en vérité, ne sont pas classés quant à leur degré de validité. Ils sont logés dans la maison d'hospitalité de telle façon qui a donné naissance à un préjugé que je citais plus haut.

Pourtant, si ces personnes étaient classées selon leur degré de validité et compétences diverses, on pourrait leur fournir à peu de frais des activités qui seraient une excellente thérapeutique. En le faisant, nous prolongerions leurs jours par le bon maintien de leur moral et nous leur donnerions l'occasion de faire valoir leurs services tout en produisant quelque chose d'utile. Il y aurait beaucoup de petits travaux manuels réalisables par ceux qui sont encore valides et d'autres possibles, à périodes intermittentes, par ceux qui sont handicappés. J'affirmerai même que le nombre de ces travaux et leur continuité pourraient être une source de revenus pour l'individu qui les pratique, et de là, un soulagement pour la société ou le particulier qui doit assumer le coût de l'entretien de telles personnes.

Je n'ai mentionné que les vieillards plus ou moins valides qui logent dans les hospices. Il ne faudrait pas croire pour cela que toutes les personnes âgées sont logées dans les hospices. La grosse majorité de ceux que nous appelons vieillards demeurent encore chez eux, chez leurs enfants, chez des parents, ou en pension, et malgré qu'un grand nombre de ceux qui ne vivent pas dans les hospices s'y acheminent par l'état progressif de leur sénilité, il restera toujours la majorité de ceux qui n'auront jamais recours à cette planche de salut.

S'il nous est possible d'organiser dans les murs d'un foyer pour vieillards certaines thérapeutiques occupationnelles, que dire des possibilités qui existent en dehors des institutions pour l'occupation de ceux qui ne sont pas encore trop handicappés. Pourquoi ne pourrions-nous pas organiser des oeuvres paroissiales consacrées à la distraction et au bien-être des vieilles personnes?

Cette oeuvre paroissiale réalisée sous la forme d'un cercle d'amis où les personnes âgées pourraient aller se distraire pendant le jour, serait certainement bien accueillie à cause des multiples services qu'elle pourrait rendre.

Cela pourrait apporter quelque lumière intéressante sur le sort des vieilles personnes qui demeurent encore au foyer. Il arrive cependant, assez souvent, que des vieilles personnes encore valides ne peuvent loger avec leurs enfants ou des proches et cherchent à se placer en pension quelque part. Ce quelque part, comme je l'ai signalé plus haut, est extrêmement difficile à trouver. Ils se refusent d'aller à l'hospice à cause de la nature de ce dernier dans sa conception actuelle, malgré la liberté que l'hospice accorde aux personnes valides. La plupart des gens hésite à adopter cette solution tant qu'ils ne sont pas rendus au stage où ils ont besoin de soins particuliers. Pour obvier à cela, je vois deux solutions possibles. La première est que par une méthode soigneusement étudiée, par un contrôle bien établi, selon toutes les règles de l'art et par une publicité soutenue, on organise un réseau de foyers adoptifs pour vieillards. Cette solution, cependant, ne pourrait être apportée que par une oeuvre sociale dûment établie, qui serait chargée d'assister les vieillards dans le besoin, comme d'assister le foyer nourricier lorsqu'il y aura lieu de le faire, advenant la maladie ou d'autres problèmes connexes. De tels foyers devraient maintenir des standards qui seraient établis par l'oeuvre sociale surveillante.

Ce serait, à mon avis, une solution magnifique, à condition que lorsque le vieillard, par son comportement ou l'état de sa santé, causera des difficultés, le foyer qui le garde puisse en être soulagé par d'autres organisations spécialement organisées pour le soin et le traitement de ceux qui se classent dans les 3e, 4e, ou 5e catégories.

La deuxième solution serait l'établissement d'une résidence dont les plans seraient tracés spécialement pour accommoder la population qui l'habite, c'est-à-dire une population de personnes âgées, mais valides, et de vieux couples. En cela, je réfère au projet ébauché à Londres, en 1946. Cette maison, si elle se réalise à Londres, portera le nom de "Isleden House," et voici ce en quoi elle consistera.

Au point de vue géographique, elle occupera un site triangulaire, formé par trois rues. De l'opinion des travailleurs sociaux qui ont étudié le problème, cette maison pourra abriter de 30 à 60 personnes, distribuées de la façon suivante:

(a) Des chambres individuelles (simples et doubles), avec pour chacune une petite cuisinette servie d'eau chaude et d'eau froide et un cabinet d'aisance, le tout formant une entité sur un plain-pied et dont les clés seraient en possession des occupants. Autant que possible, les meubles devraient être construits à même les murs afin de réduire l'entretien au minimum.

(b) Une chambre commune dans laquelle le repas du midi pourrait être servi à ceux qui habitent la maison, les autres repas pourraient être préparés par les résidents eux-mêmes, dans leur propre chambre. Ce facteur est d'une importance particulière parce que le magasinage constitue un des principaux intérêts des vieilles personnes. Cette chambre commune destinée à servir de réfectoire, à l'heure du midi, pourrait être transformée en salon commun, genre "club room" pour l'après-midi et le soir.

(c) Une chambre pouvant accommoder au moins deux personnes.

(d) Une buanderie où les résidents feraient leur propre lavage.

(e) Une salle de repos.

La maison devrait être dirigée par une surintendante, de préférence une garde-malade graduée, pouvant traiter les maladies bénignes dans l'infirmerie. Les résidents auraient la liberté d'apporter leurs meubles ou telles pièces approuvées par l'administration. Des arrangements se feraient pour le nettoyage général de ce petit logement à chaque semaine. La tâche du petit entretien serait laissée aux vieilles personnes.

La maison "Isleden" sera tentée à titre d'expérience. Si cette expérience réussit, on en bâtira d'autres dans diverses régions de Londres.

Au premier plancher, 22 petits plain-pieds pour une seule personne; 9 petits plain-pieds pour deux personnes. Au premier plancher, 9 plain-pieds pour des familles de trois personnes; 5 plain-pieds pour des familles de 4 et 5 personnes. Les deuxième et troisième planchers seront disposés de la même façon que le premier.

Voici donc, mes chers amis, la deuxième solution que j'avais à vous offrir. En réalité, cette solution n'est pas complète. Il faudrait, pour qu'il n'y ait plus de problèmes dans l'assistance sociale ou l'organization sociale de la vie des personnes âgées, qu'on s'attarde à réaliser chacune des étapes que je vous ai mentionnées, partant de l'aménagement des hospices en passant par l'organization de services sociaux, hors les murs, comme d'une organization paroissiale pour personnes âgées, de foyers adoptifs pour vieillards et cette résidence pour ceux qui ont peu ou n'ont point de famille.

Old Age Pensions Act

New agreements under this Act, as amended at the last session of Parliament, have been signed with all of the provinces. The amended Act obligates the Federal Government to pay 75 per cent of the net cost of pensions up to a maximum of $30 per month per pensioner and leaves the provinces free to pay additional amounts over that rate. During the past few years, six provinces have been paying supplemental allowances in addition to the basic pension. The addition varied between provinces, the highest being $10 per month.

Nursing Profiles

Implementing a policy of making the staff as well as the student body international, the school of nursing of the University of Toronto has appointed **Elizabeth Katherine McLaughlin** as lecturer in nursing. Miss McLaughlin was born in California of Scottish-Irish parentage. She received her Bachelor of Arts degree from Tulane University, New Orleans, and graduated from the Johns Hopkins Hospital, Baltimore, in 1937. After a year in public health nursing she spent two years in Colombia, South America, on a hospital staff, then returned to Johns Hopkins. In 1942 she joined the U.S. Army Nurse Corps and saw service in China, Burma, and India, receiving her discharge in 1946 with the rank of Captain. She enrolled at Teachers College, Columbia University, and received her Master's degree from that institution in 1947.

Elva May Cranna has been superintendent of nurses at the Brandon Mental Hospital, Man., since the completion of her course in supervision in psychiatric nursing at the McGill School for Graduate Nurses.

Following graduation as a mental nurse from the Brandon Hospital in 1938, Miss Cranna desired to further qualify herself and entered the school of nursing of the Vancouver General Hospital where she graduated in 1942. After a brief period in general duty at the V.G.H. she returned to the Brandon Mental Hospital as head nurse of the women's infirmary, later becoming dispensary nurse, then nursing arts instructor.

Miss Cranna is a keen sportswoman, enjoying curling, skating, and hockey in the winter, camping in the summer. Her hobbies of leathercraft and knitting occupy her spare moments.

Marjorie Anne Rutherford has assumed her duties as regional supervisor, Division of Public Health Nursing with the Ontario Department of Health.

Born and educated in Mount Forest, Ont., Miss Rutherford graduated from the Victoria Hospital, London, in 1932. The following year she secured her certificate in public health nursing from the University of Western Ontario and joined the staff of the provincial Department of Health immediately. In 1937 she was loaned to the Ontario Society for Crippled Children for one year during the polio epidemic. In 1941 she enlisted with the R.C.A.M.C., spending two years at the Kingston Military Hospital before going overseas. She was principal matron of No. 2 Canadian General Hospital in England and of No. 5 Canadian General Hospital in Italy and Belgium.

Upon her discharge from military service, Miss Rutherford was appointed supervisor

Bachrach

ELIZABETH MCLAUGHLIN

Hardy, Vankleek, Ont.

MARJORIE RUTHERFORD

Thams Studios, Saskatoon

ETHEL JAMES

of the Elgin-St. Thomas Health Unit. In 1946 she enrolled in the school of nursing of the University of Toronto for the advanced public health nursing course in administration and supervision. On completion of the course, she rejoined the provincial Department of Health and her present appointment followed.

Ethel Colvin James is the educational director at Regina General Hospital, Sask. Graduating from the Royal Alexandra Hospital, Edmonton, in 1930, Miss James has had varied experience which included six years of general staff nursing at the University of Alberta Hospital and two years' private duty in Edmonton. In 1941 she became a supervisor at Saskatoon City Hospital, later serving there as instructor, assistant director, and director of nursing. Immediately prior to her present appointment, Miss James was instructor at the Yorkton General Hospital. Miss James has always been keenly interested in professional activities, serving as vice-president of the Saskatoon Registered Nurses Association for two years and later as chairman of the Hospital and School of Nursing Section with the S.R.N.A. Recently she has assumed the duties of the presidency of the S.R.N.A.

Olive Thomas, who is superintendent of nurses at the Brandon General Hospital, Man., was formerly registrar of the Placement Bureau of the Manitoba Association of Registered Nurses. A graduate of the Winnipeg General Hospital, Miss Thomas had varied experiences in several parts of Canada, the most interesting of which was her work among the Indians in the North.

Jerrett, Brandon

OLIVE THOMAS

Anne Campbell Ballantyne, who graduated from the Stratford General Hospital in 1935, has been appointed director of nurses at the Freeport Sanatorium, Kitchener, Ont. For five years following graduation, Miss Ballantyne engaged in private duty nursing, returning in 1941 to her home hospital as nursing x-ray technician. In September, 1944, she enrolled at the school of nursing of the University of Toronto for the course in hospital administration after which she became assistant superintendent of the Stratford General Hospital for a year. Further experience as records historian and as assistant to the business administrator in the Peter-

ANNE BALLANTYNE

JEANNETTE WATSON

borough Civic Hospital have admirably fitted her for her new duties.

Harking back to her childhood days on a farm, Miss Ballantyne is fond of rural life especially horseback riding; books, knitting, cycling also provide occupation for her leisure hours.

Jeannette E. Watson, who graduated from the Guelph (Ont.) General Hospital in 1928, has been appointed director of the school of nursing of the Galt (Ont.) General Hospital. Post-graduate courses in surgery at the Hospital for Sick Children and at the Toronto Western Hospital, and a course in teaching and administration at the Toronto University School of Nursing, have given Miss Watson an excellent theoretical background. Her experience includes five years as night supervisor and six years as instructor of nurses at the Guelph General Hospital.

MARGARET G. WEST

Margaret Grace West has assumed her duties as superintendent of the newly-erected Saugeen Memorial Hospital at Southampton, Ont. Graduating from the Hamilton General Hospital in 1937, Miss West spent several years as a supervisor at the Norfolk General Hospital, Simcoe. In 1943, she enlisted as a nursing sister with the R.C.A.F., serving there until the end of hostilities. A short period as matron of the Creston Valley (B.C.) Hospital preceded her enrolment at the University of Western Ontario, London.

Miss West is interested in most sports, is fond of music, and enjoys gardening.

Alice Young is the new superintendent of nurses at the Public General Hospital, Chatham, Ont. Born and educated in England, Miss Young graduated from Crumpsall Hospital, Manchester, receiving her contagious diseases training in Liverpool and holding also her C.M.B.

From 1929 to 1942 Miss Young served in various positions at the Mount Sinai Hospital, Toronto, becoming director of nursing education at the Collingwood General Hospital in 1943. She also holds a certificate for teaching in schools of nursing from the University of Toronto.

Jessie Lee McIntyre, a native of Grand Valley, Ont., who graduated from the Farrand Training School, Harper Hospital, Detroit, in 1927, is the superintendent of the Strathroy (Ont.) General Hospital. Prior to this appointment all of Miss McIntyre's professional experience had been in the United States where for four years she was supervisor of obstetrics

ALICE YOUNG

at Harper Hospital and from 1937 to 1947 supervisor of obstetrics at the Port Huron (Mich.) Hospital.

Bertha Jenkins is at present matron of the King's Daughters' Hospital, Duncan, B.C. A native of Wales, Miss Jenkins graduated from the Vancouver General Hospital in 1926, receiving her certificate in public health nursing from the University of British Columbia two years later. Her varied experience includes school nursing in Vancouver, a year with the Vancouver Branch of the Victorian Order of Nurses, supervisor of the Cowichan Health Centre and of the Saanich Health Unit. In 1942 she enlisted with the R.C.A.M.C. and saw service at various points in Canada and on the hospital ship *Letitia*. Following her discharge from the army, she served as matron of the outpost hospital in Kyuquot, B.C., for one year prior to her present appointment.

Miss Jenkins has developed her hobby of photography to a fine art, specializing in color photography, including movies and stills.

Catherine Macinnes Ferguson, who has been lady superintendent of the Alexandra Hospital in Montreal since 1920, has retired. Born and educated in Scotland, Miss Ferguson graduated from the Royal Infirmary, Greenock, in 1910. Following graduation she undertook a year's post-graduate study in the treatment and nursing care of communicable diseases at the Belvedere Hospital, Glasgow, and has specialized in that work ever since, except for an interval during the first World War when she served as a nursing sister with the Q.A.I.M.N.S. She was attached to the Reading War Hospitals and received the Associate of the Royal Red Cross in recognition of her war services.

Miss Ferguson's contribution to the education of student nurses is well known through Canada. Students from all the English-language schools of nursing in Quebec, from several schools in the Maritimes, Vermont, and Bermuda have learned this valuable branch of nursing through affiliation with her school. Some 4,300 students and graduate nurses have shared this experience under her guidance.

Always ready to identify herself with nursing education and progress, Miss Ferguson has held several offices on the Committee of Management of the Registered Nurses Association of the Province of Quebec, and was among the pioneers of that organization through which she gained an international reputation for administrative ability by her contribution to the work of the local committee in charge of arrangements for the sixth Quadriennial Congress of the International Council of Nurses held in Montreal in 1929.

CATHERINE FERGUSON

Miss Ferguson plans to make her home in Vancouver, B.C.

Jane Alice Murphy, who has been associated with the Montreal General Hospital for thirty-three years, twenty-seven of which she served as supervisor of the Out-Patients Department, has retired. Graduating from the M.G.H. in 1917, Miss Murphy was placed in charge of the soldiers' ward and a few

Notman, Montreal

JANE MURPHY

months later was appointed sister-in-charge of Ward G. In 1920 she was appointed supervisor of the Out-Patients Department. Under her efficient management the department has been extended until it has handled an enormous number of patients each year. She was largely responsible for the establishment of a canteen in the department so that patients who had to wait for afternoon appointments were able to obtain light lunches, in many cases without charge.

At a tea in her honor, Miss Murphy was presented with a purse as a gift from the consulting and attending staffs. Tribute was paid to her efficiency and loyal service over such a long period.

Phyllis Walker, who served as a nursing sister overseas with No. 14 Canadian General Hospital, has been appointed to succeed Miss Murphy.

Elizabeth Richardson, who has been superintendent of Aberdeen Hospital, New Glasgow, N.S., since 1944, has retired. Miss Richardson is a graduate of the Jeffery Hale's Hospital, Quebec City, and for ten years was superintendent of Shawinigan Falls Hospital. For five years she was superintendent of the Blanchard-Fraser Memorial Hospital, Kentville, N.S. and also served at the Children's Hospital, Halifax. Miss Richardson had planned to retire earlier but felt that during the war years her services should be continued.

After twenty-eight and a half years of continuous service, **Ella (Binks) McCuaig** has retired from the Victorian Order of Nurses. Mrs. McCuaig, after her graduation from the Royal Victoria Hospital, did private duty at Presbyterian Hospital in New York City. Following this she joined the Henry St. Visiting Nurses Association and remained there for two years. In 1918 she came to Montreal and joined the V.O.N. staff. After a few months in district work, she was transferred to the statistical department which she managed until her retirement.

Her most interesting leisure-time hobby is water colors and she used this talent generously to give pleasure and color to many of the staff social activities. Her outstanding artistic ability which she applied to her work was much appreciated by the organization. She could turn dull statistics into interesting colorful graphs. Her gay and interesting personality has made for her many friends everywhere. Mrs. McCuaig will be greatly missed by all her associates but we wish her much happiness in her retirement.

In Memoriam

Mildred Louise (Shuttleworth) Galbraith, a graduate of the Hamilton General Hospital, died in Calgary in October, 1947, after a prolonged illness. Following graduation, Mrs. Galbraith undertook post-graduate study in Brooklyn, N.Y. She engaged in private duty in Hamilton prior to her marriage.

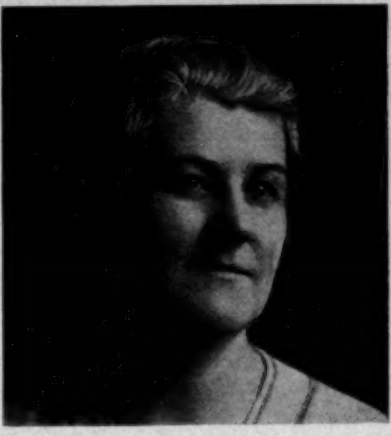
It is with a deep sense of professional loss that the recent death of **Elsie Hickey** is recorded. A graduate of the school for nurses of the Toronto General Hospital in 1913, Miss Hickey joined the staff of the Department of Public Health of Toronto in 1915 and for the past ten years has been the director of the Division of Public Health Nursing.

In reviewing the contribution which Miss Hickey made to the community's health and to professional work as a whole, there are brought into relief certain qualities, the most striking of which were a warmth of personality and a spirit of magnanimity which engendered the establishment of favorable human relationships. This was evidenced in the furtherance of sound personnel policies within the Division and a pronounced interest in the welfare of the community which the Division exists to serve. Nor was her effort confined to the practice of public health nursing. Always she was concerned with new and better ways of preparing young women for the public health field and in their growth following appointment. To this end, an exceedingly close and fruitful relationship existed between the school preparing the worker and the employing agency through which health service is rendered.

Miss Hickey's activity extended beyond

the Division to which she gave leadership, for as a trusted member of the Health Division of the Toronto Welfare Council she shared in joint planning for the improvement of the community's total health and welfare services. An experienced committee member, she assisted also in the work of the Ontario Division of the Canadian Red Cross Society, the Registered Nurses Association of Ontario, and the Canadian Public Health Association.

As a pioneer in the health area of community work, Miss Hickey's influence will continue to be felt through those whom she inspired, through example, to accentuate humanitarian values in professional work and in the broader relationships of life as a whole.



ELSIE HICKEY

Mary B. Hubbs, who served as a nursing sister in World War I, died in Kingston, Ont., last October in her seventieth year. Miss Hubbs was awarded the Royal Red Cross Medal (first class) for her heroism at Etaples when the military hospital was bombed. For a time, she was in charge of the amputation division of the military hospital at Bucks, England. Following the war, Miss Hubbs was on the nursing staff of Christie St. Hospital, Toronto. She was a county school nurse for a time. Declining health, however, compelled her to give up professional activity and of recent years she had been retired.

Gladys Grace Martin, who graduated from Jeffery Hale School for Nurses, Quebec, in 1941, died in Montreal on November 3, 1947, after a lengthy illness. Following graduation, Miss Martin took post-graduate training in teaching and supervision at the McGill School for Graduate Nurses. She had been engaged in the teaching department of her home school. Uniformed nurses formed a most impressive guard of honor at the funeral service in Quebec.

Mary (Lee) Robertson, who graduated in 1938 from the New Toronto Ontario Hospital, passed away suddenly at the age of thirty-four years. Mrs. Robertson had been on the staff of her home hospital since graduation.

Decorations Won by Canadian Women

More than four hundred Canadian women won decorations during the war. Although none won a Victoria Cross — the Empire's highest award for gallantry — decorations were awarded for courage and devotion to duty when the going was "rough."

Majority of the awards went to nursing sisters who served with the Royal Canadian Army Medical Corps. They received 272 decorations, ranging from the Officer of the Order of the British Empire to a Czech decoration for merit. There were 104 army nurses mentioned in despatches.

The Women's Division of the R.C.A.F. received 14 awards of Member of the Order of the British Empire and 39 British Empire medals. Fifty were mentioned in despatches for a total of 103 decorations. The C.W.A.C. and the W.R.C.N.S. received 84 and 22 decorations respectively.

Don't Forget!

The poster competition sponsored by the *Journal* is swinging into the closing weeks. Entries should reach Montreal by the beginning of March. Send them along now if you have them ready.

Don't forget — there is a fifteen dollar prize waiting for some nurse in each province. Don't let your province's prize go unawarded. What student nurse could not use that money just before Easter! And there is always the chance you may win the grand prize in addition.

Notes from National Office

Provincial Association Reports

The interim reports of the provincial Registered Nurses' Associations, as presented to the meeting of the Executive Committee, C.N.A., December 5-6, 1947, are briefly summarized as follows:

Alberta Association of Registered Nurses: An excellent institute on Tests and Measurements was given in June, 1947, by Miss Helen Penhale, director of nursing, University of Alberta, and Rev. Sister Jeanne Forest. A request has been made for another institute to be held in 1948 which would be of special interest to staff nurses in general.

The association, with approval of the Associated Hospitals of Alberta, is urging hospital boards and nurse employees to jointly formulate specific personnel policies for nurses employed in each Alberta hospital and to provide present and future employees with a copy and agreement; to jointly revise the policies annually prior to the end of each fiscal year.

A plan, whereby nurses from among the displaced persons in Europe might be brought to Alberta, was contemplated by the Department of Public Health. However, they were informed by Ottawa that nurses were not available from among this group and activity in this regard is at a standstill.

Registered Nurses' Association of British Columbia: The past six months has brought an increase in volume resulting in an expansion of the work of the Placement Service. The nurses are realizing more and more that the information regarding nursing opportunities, which is very detailed and always up-to-date, enables them to select positions with greater confidence and ease. An analysis of the experimental placement of practical nurses for a twelve-month period has been made from reports submitted by doctors, nurses, patients, and especially by the practical nurses themselves. The findings are as follows:

1. The diagnosis, as given by the physician, has not always proved a reliable guide to nursing requirements.
2. Experience in domestic management and willingness to assume responsibilities in the home are deciding factors in the usefulness of the practical nurse. It is often not so much a matter of doing all the work as knowing what is necessary without being told. Where the patient is the housekeeper the state of the home is important to her peace of mind and recovery.
3. Practical nurses, who have been freelancing for years, frequently over-rate their knowledge and skill and do not fully cooperate with the directory.
4. Non-registered graduate nurses who enrolled have appeared less eager than the partially trained to undertake advanced procedures in the home.
5. Many practical nurses interviewed were not enrolled. The two major reasons for this were their seeming unsuitability for the work and their reluctance to accept the fee schedule and other restrictions imposed by registry enrolment.
6. Patients and the families of patients have expressed appreciation for the careful selection of practical nurses and other safeguards established.

It has been very evident for several years that the rural areas have suffered more than urban areas from nursing service shortage. An average of 439 vacancies have been listed with the Placement Service each month during the past year. With 73.27 per cent of the hospital beds in the four major communities of the province, 62.74 per cent of the shortages have been experienced in the other communities.

Implementation of the 1947 personnel practices has meant that the basic minimum gross salary of $140 per month has become pretty well established. Four weeks' vacation and a full day for each statutory holiday have been generally accepted. The principle of sick leave allowance has also been generally accepted. Very few hospitals have been able to introduce a work week of less than forty-eight hours.

The major project for the Labor Relations Committee for the year has been the preparation of a fact sheet on labor relations for distribution to districts, chapters, and industrial members.

The Department of Labor has certified bargaining representatives elected by the nursing staff of the Prince George General Hospital. Bargaining units are now established for eight hospitals and one visiting nurse organization. Two other nursing staffs have taken the initial steps toward electing bargaining representatives. Formal agreements are being drafted for each bargaining unit, copies of which will be given to each nurse concerned.

The number of nurses from Great Britain and other countries making enquiries or arriving in British Columbia is growing. This association is gravely concerned over the high proportion of these nurses whose qualifications are considerably below the minimum registration requirements for this province.

Manitoba Association of Registered Nurses: The care of the sick for remuneration by persons other than registered graduate nurses and licensed practical nurses is illegal by law in Manitoba and such persons may be prosecuted. Since the registration of graduate nurses has always been permissive, never mandatory, some graduate nurses without registration have been gainfully employed in the province for a number of years and have rendered commendable service. However, having neglected to present themselves for the examination for registration, as required by the Act for the Registration of Nurses, they never possessed the privilege nor security of a legal professional status. Such nurses now found themselves in an embarrassing position and faced with two alternatives, namely: (a) To submit themselves for the current registration examination or (b) become licensed practical nurses. An understandable reticence, mixed with fear and humiliation, made either course unacceptable, especially since the registration examinations are now based upon a curriculum of studies vastly different from that taken by student nurses prior to September, 1941.

Recognizing the valuable service rendered by such graduate nurses in the past and at the present time, the Board of Managers of the Manitoba Association of Registered Nurses has arranged for a special examination for nurses who graduated prior to September, 1944 and, having failed to present themselves for registration at that time, now wish to legalize their status to conform with present legislation. The senate of the university gave approval to such special examination and to the appointment of a special committee to examine by interview and written examination those nurses who present themselves. The examinations were held in December, 1947.

The members present at the last annual meeting unanimously endorsed the formation of an Advisory Committee to the Board of Managers. This committee will be formed early in 1948.

New Brunswick Association of Registered Nurses: The minimum curriculum is being revised by the Committee on Institutional Nursing. A plan for first-year examinations is under study in the province.

A recommendation that the fee for nursing two patients be $2.00 more than the regulation fee for one patient, but that not more than $3.00 over and above the regulation fee for any number of patients, was approved at the annual meeting.

A decision to form a student nurses' association was made at the annual meeting. Miss Dorothy Parsons, Fredericton, was appointed chairman of the committee to organize this group.

Registered Nurses' Association of Nova Scotia: Correspondence has been had with the Hon. F. R. Davis, Minister of Public Health, Province of Nova Scotia, in respect to the request by Dr. M. I. Mandryka, chairman of Settlement Commission, Ukrainian Canadian Committee, for admission to membership in our association of Ukrainian nurses in the status of displaced persons. Dr. Mandryka was advised that, subject to admission to Canada by Canadian immigration authorities and in compliance with our other requirements, we would not be opposed to admission of such nurses to membership.

Recommendations have been made to the Nova Scotia Department of Education that consideration be given to a revision of the present curriculum for high school students who plan on entering the nursing profession, by making the following subjects obligatory: English, algebra, geometry, history, physics and chemistry, or household economics and chemistry, and French. It was pointed out to the department that pass marks obtained in the above subjects would qualify the student for university entrance. The department noted that our present Act requires only possession of a full Grade XI Provincial Pass Certificate or its equivalent and pointed out that an amendment to our existing Act is necessary if the above-mentioned subjects are to be made compulsory. Our suggestions have been sent, over the signature of the department, to the principals of all high schools in the province.

Enquiry was directed to Miss Gauthier, registrar of nurses and attendants, Commonwealth of Massachusetts, with respect to advertisements appearing in the local press, making an appeal to Maritime students to enter training in a hospital in Massachusetts. Miss Gauthier's reply was to the effect that no such student, upon graduation, would be examined for registration until such time as she presented a copy of her declaration of intention to become a citizen of the United States and further, "To my knowledge a person in the United States on a student visa may not apply for a declaration of intention." This information has been supplied to all branches of our association.

A draft of the proposed Bill, to provide for the licensing of practical nurses, is now being drawn up and will, when finished, be mimeographed and forwarded to every member of our association for study and comment.

Registered Nurses Association of Ontario: It is hoped that the draft of our nursing bill will be presented to the Legislature early in 1948.

Seven association loans, totalling $3,300, have been granted to members to assist them in taking post-graduate courses. Since 1944, the Ontario Department of Health has awarded bursaries to carefully selected graduate nurses for post-graduate study at an Ontario university. So far 149 bursaries have been granted for certificate work in public health nursing, 18 for the advanced course in administration and supervision in public health nursing, and 17 for a course in teaching and supervision in schools of nursing. Each recipient has pledged service in Ontario following completion of her course.

A committee has been appointed to study personnel practices and salary schedules for nurses in various types of positions in the different fields of nursing.

The first draft of the proposed revision of the minimum curriculum has been prepared. Part I of the registration examinations will examine students, who have completed one year of training, in anatomy and physiology and principles of nursing technique.

The Nurses' Act of 1947 provides for the training and registration of nursing assistants. To date there has been an enrolment of over three hundred.

Prince Edward Island Registered Nurses' Association: The Legislation Committee has given serious study to the revision of our Act. The standing of our provincial high schools in relation to Canadian universities is not yet clear.

Association of Nurses of the Province of Quebec: At the request of the secretary of the Danish Nurses Association, we have negotiated for the reception of selected nurses from Denmark to secure staff positions in our hospitals which would provide for each one specific experience. We have made all arrangements and are pleased to record that six of these nurses are with us. We have made plans for another group of seven for whom positions have been assured. All those who have already arrived have been granted reciprocal registration and a licence to practise and all others are eligible and will receive both. We feel that any exertion on our part in these negotiations will pay dividends.

Activities relating to the preparation of auxiliary nursing workers have been speeded up considerably and we are preparing to meet representatives of the three hospital councils within the province to consider proposals from those groups in relation to our revised plan. We expect to have one or more schools established and ready to function by the end of 1947 and plans completed for adequate legislation covering these workers.

Present student capacity of the schools of nursing in this province is thirty-six hundred. The four largest schools, two of each language group, are filled to capacity. The smaller schools are less fortunate. Some 350 more students could be handled than are at present enrolled.

Our returns to the Canadian Nurses' Association at end of third quarter recorded 6,310 members. Our annual licence fee is deductible from income tax because it is compulsory.

Two Jeanne Mance Scholarships of $500 each have been awarded again this year by our association, also three more from District 11—two of $300 each from the French Chapter and one of $500 from the English Chapter.

Saskatchewan Registered Nurses' Associ-

ation: The Health Services Planning Commission has formed a sub-committee on hospital planning to act in an advisory capacity. This association has representation on this sub-committee.

The appointment of Miss Margaret Heeney, as nurse inspector of hospitals under the Health Services Planning Commission, took place earlier in the year. Her responsibilities include the visiting of hospitals in rural areas.

The provincial government has once more granted financial assistance to support the work of the Nurse Placement Service, which will be continued. It is gratifying to note that, more and more, nurses are making use of this service, not so much to seek placement under present conditions, but in the solution of personal problems.

The One Day Rest in Seven Act is now in effect for all nurses working in hospitals in cities or towns with a population of one thousand or over.

A written contract between the employer and nurse has been recommended and a suggested form drawn up on behalf of this association. This is designed to cover all conditions of employment, as far as this is possible. It is felt that it will tend to produce a better employer-employee relationship and assist in the stabilization of nursing service. The recommendations for conditions of employment prepared by this association have been quite generally adopted by hospital authorities throughout the province.

The establishment of the 48-hour week, with one day off in seven, is in effect now in most schools of nursing in the province. In one school a complete block system of instruction has been inaugurated for the second-year students. These students are relieved from all ward duty while attending classes, except for one day each week when they are on the wards for the entire eight hours.

There is some question regarding the soundness of attempting to teach a large number of different subjects in the short period of fifty days allotted to the students, without much direct correlation with ward experience. However, so long as the other students are protected by the employment of a sufficient number of graduate nurses to supplement the nursing service, the experiment seems very well worthwhile and possibly the most desirable solution under conditions which exist in schools of nursing today. Under the conditions cited, it was endorsed by the Council of the Saskatchewan Registered Nurses' Association as a most progressive development.

Notes du Secrétariat de l'A.I.C.

Les rapports présentés par les associations provinciales des infirmières au conseil exécutif de l'Association des Infirmières du Canada, le 5 et 6 décembre 1947, sont brièvement résumés ici:

Alberta: Mlle Helen Penhale, directrice du nursing à l'Université d'Alberta, et la révérende Soeur Jeanne Forest furent les conférencières très appréciées lors de la journée d'étude tenue en juin dernier. Le sujet traité fut: Tests et psychométrie.

A la demande générale, une nouvelle journée d'étude pouvant intéresser les infirmières en service général sera organisée en 1948.

L'Association des Infirmières, appuyée par l'Association des Hôpitaux de l'Alberta, fait une pression auprès des bureaux de direction des hôpitaux et auprès des employeurs afin qu'une ligne de conduite bien définie soit établie à l'égard des infirmières employées dans chaque hôpital de l'Alberta et qu'une copie de l'entente soit remise à chaque employée actuelle et future.

Avant la fin de chaque année cette entente devra être revisée.

Le département de la santé de l'Alberta avait considéré le plan de faire venir d'Europe des infirmières actuellement dans les camps des personnes déportées. Ottawa nous informe qu'il n'y a pas d'infirmières disponibles parmi ce groupe et les démarches faites en ce sens sont arrêtées.

Colombie-Britannique: Le bureau de placement est très actif. Les infirmières se rendent de plus en plus compte qu'il leur

est plus facile d'accepter une position lorsqu'elles peuvent se procurer sur place tous les renseignements désirés.

A titre d'expérience, l'on a fait une analyse concernant le placement des aides. Durant une année des rapports ont été soumis par des médecins, des infirmières, et tout particulièrement par les aides elles-mêmes. Voici le résultat:

1. Il n'a pas toujours été possible de se guider sur le diagnostic donné par le médecin pour savoir si la malade requérait les services d'une infirmière ou d'une aide.

2. Une certaine expérience dans la tenue d'une maison et la bonne volonté de prendre les responsabilités de la maison sont des facteurs déterminant l'emploi de l'aide. Il ne s'agit pas tant pour elle de faire tout le travail de la maison, mais d'être capable de faire le nécessaire sans que l'on ait à lui dire.

3. Les aides faisant du service depuis au moins trois ans souvent pensent avoir plus de connaissances qu'elles en ont réellement et ne co-opérent pas toujours avec le bureau de placement.

4. Les infirmières non enregistrées n'ont pas la même attitude que les aides citées en paragraphe 3. Elles hésitent avant de faire des traitements pour lesquels elles n'ont pas été préparées.

5. Plusieurs aides ont refusé de faire partie du registre. Les deux principales raisons sont leur inaptitude pour ce genre de travail, le salaire imposé et la soumission à un règlement.

6. Les familles et les institutions ont apprécié le choix fait par le registre dans le placement des aides.

Il est évident que depuis plusieurs années que les régions rurales ont manqué d'infirmières plus que les régions urbaines.

Conditions de travail: Le salaire minimum de $140 par mois est pratiquement établi partout. Les quatre semaines de vacances et une journée de congé lors d'une fête légale ont aussi été acceptées. Le principe du congé en maladie a aussi été accepté. Très peu d'hôpitaux ont pu introduire la pratique de la semaine à moins de 48 heures.

Le nombre d'infirmières venant de Grande-Bretagne ou d'autres pays d'Europe demandant des renseignements ou arrivant en C.B. va en augmentant. L'association de notre province est très préoccupée du fait qu'un grand nombre de ces infirmières n'ont pas les qualifications minimums exigées en C.B.

MANITOBA: Seules les infirmières enregistrées et les aides licenciées ont le droit de recevoir un salaire pour les soins qu'elles donnent aux malades. Il est illégal pour tout autre personne de le faire et ces personnes peuvent être poursuivies.

Comme l'enregistrement pour les infirmières n'a jamais été obligatoire dans le sens légal du mot, il s'en suit qu'un certain nombre d'infirmières ayant négligé de s'enregistrer se trouvent dans une bien mauvaise position. Elles n'ont d'autres alternatives que (a) se présenter aux examens de l'enregistrement (b) de se faire reconnaître comme aide.

Quelques-unes étant déjà d'un certain âge, il leur est difficile de passer les examens actuels et elles se trouvent dans une situation humiliante. Pour leur venir en aide un examen spécial sera tenu pour les gardes-malades diplômées avant septembre 1944 et ayant négligé pour une raison ou pour une autre d'obtenir leur statut professionnel.

NOUVEAU-BRUNSWICK: Le programme d'étude est revisé par un comité spécial. L'on étudie également la possibilité d'un examen d'enregistrement après la 1ère année.

Lors de la dernière assemblée générale, la décision fut prise d'organiser une association d'étudiantes-infirmières.

NOUVELLE-ECOSSE: Nous avons échangé quelques lettres avec le ministre de la santé au sujet de la demande faite par le Dr. M. I. Mandryka, président d'une société ukrainienne, concernant l'admission dans notre association d'infirmières ukrainiennes actuellement dans les camps de personnes déportées.

Le Dr. Mandryka fut informé qu'en autant que ces personnes seraient acceptées au Canada par le département de l'immigration et en autant qu'elles répondraient aux demandes de notre association provinciale ces personnes seraient acceptées comme membres.

Une recommandation a été faite au département de l'éducation concernant une revision du programme d'étude afin de favoriser les élèves désireuses de suivre un cours d'infirmières. L'on demande que les matières suivantes soient obligatoires: l'anglais, l'algèbre, la géométrie, l'histoire, la physique et la chimie ou les sciences familiales et la chimie, et le français.

Une annonce parue dans les journaux des provinces maritimes, demandant aux jeunes filles de s'inscrire aux Massachusetts comme étudiantes gardes-malades et comme aides, a été portée à l'attention de la registraire de cet état.

La réponse de la registraire fut qu'aucune de ces étudiantes ne serait admise aux examens d'enregistrement, à moins, qu'elle présente une déclaration écrite attestant son intention de devenir sujet américain.

Le projet de loi, ayant pour but d'obtenir une licence pour les aides, est terminé et sera soumis à tous les membres de l'association pour étude.

ONTARIO: La loi des infirmières de l'Ontario sera présentée à la législature au début de 1948.

Une somme de $3,300 fut prêtée à sept de nos membres dans le but de leur aider à faire des études post-scolaires. Depuis 1944, le ministère de la santé a accordé des bourses à des infirmières leur permettant d'étudier dans une université de l'Ontario.

La première partie de la revision du programme d'étude est complétée. La première partie de l'examen d'enregistrement aura lieu après la 1ère année et sera sur les matières suivantes: anatomie et physiologie, les principes du nursing, et les techniques du soin aux malades.

La loi des infirmières de 1947 permet la formation et l'enregistrement d'aides. A date trois cents personnes se sont inscrites.

ILE-DU-PRINCE-EDOUARD: Le comité de législation étudie sérieusement la revision de notre loi. Les conditions d'admission aux universités canadiennes de nos finissantes des "High Schools" ne sont pas bien définies.

QUEBEC: Plusieurs infirmières du Danemark ont demandé des positions dans nos hôpitaux, en service général, afin d'obtenir une certaine expérience. Six d'entre-elles sont actuellement dans nos hôpitaux et un autre groupe de sept est attendu. Ces infirmières ont obtenu leur enregistrement par réciprocité.

Le comité des aides a travaillé de pied ferme et nous nous préparons à rencontrer trois conseils des hôpitaux de la province afin d'étudier notre proposition. Nous espérons établir une école d'aides d'ici la fin de 1947 et terminer un projet de loi concernant ces aides.

Le nombre d'étudiantes actuellement dans nos écoles est 3,600. Nos quatre grandes écoles aussi bien anglaise que française ont toutes les élèves qu'elles peuvent accepter. D'autres plus petites sont moins favorisées, environ 350 étudiantes de plus auraient pu être admises.

Deux bourses d'étude, dites de Jeanne Mance de $500 chacune, furent accordées par notre association. L'association divisionnaire no XI en accorda aussi trois—le chapitre français en donna deux de $300 et le chapitre anglais une de $500.

SASKATCHEWAN: Une commission de service de santé a formé un sous-comité consultatif sur la construction d'hôpitaux. Des membres de notre association ont été nommés sur ce sous-comité.

Mlle Margaret Heeney fut nommée inspectrice des hôpitaux au début de l'année. Le gouvernement provincial a donné un nouvel octroi au bureau de placement. Les infirmières, de plus en plus, se réunissent au bureau non seulement pour obtenir des positions mais aussi pour y discuter de leurs problèmes.

La loi dit: "Une journée de repos sur sept" est maintenant en vigueur. Elle s'applique à toutes les infirmières employées dans les hôpitaux des villes et cités ayant une population de 1,000 habitants ou plus.

L'association a recommandé un contrat entre employeurs et infirmières. Un modèle sera préparé par l'association. Nous espérons par cette entente rendre les relations meilleures entre employeurs et employées et stabiliser les services des infirmières.

Une expérience sera tentée concernant le programme d'étude. Elle consiste à enseigner une partie des différentes matières au programme durant cinquante jours sans qu'il y ait corrélation entre la théorie et la pratique.

Cette expérience est intéressante. Il y a tout avantage à la tenter en autant que les intérêts des autres étudiantes sont protégés, c'est-à-dire en autant qu'il y a suffisamment d'infirmières diplômées pour assurer le soin des malades. L'association approuve cette étude.

Plastic Lung

A "Blanchard Mechanotherapist," or plastic lung, is now being used at Victoria (B.C.) Veterans' Hospital for the treatment of patients suffering from circulatory diseases. A transparent plastic shell surrounds the patient's chest, sealed at the neck, axilla, and waist with rubber sheet bands. It is connected to a mechanical power unit by an accordion-type bellows which synchronizes with the patient's breathing. —*Canadian Hospital.*

Annual Meeting in New Brunswick

The thirty-first annual meeting of the New Brunswick Association of Registered Nurses was held in the Admiral Beatty Hotel, Saint John, N.B., September 17-18, 1947, with an attendance of 144. The two-day session was opened with Miss M. Myers presiding at all sessions. The invocation was offered by the Most Rev. P. A. Bray, Bishop of Saint John. The address of welcome was given by Deputy Mayor, Mr. E. W. Paterson. The president welcomed Miss Winnifred Cooke, assistant secretary, Canadian Nurses' Association, who brought greetings from National Office. The president also extended a welcome to a group of student nurses who were present at an annual meeting for the first time.

In her presidential address the president stressed the activities of the national and provincial associations in the past year; the incorporation of the Canadian Nurses' Association had been accomplished; the Congress of the I.C.N. had been held in Atlantic City. For the coming year in the province one of the most important projects is the instituting of a definite minimum curriculum for schools of nursing to be followed by qualifying examinations. A further revision of the New Brunswick Association of Registered Nurses' Constitution and By-laws is being undertaken this year, but the largest and most interesting project for the immediate future is the holding of the general meeting of the Canadian Nurses' Association in Sackville in 1948.

The secretary's report showed an active membership of 896; non-resident, 278; associate, 140; 37 members lapsed; 58 resigned; 124 reported being married; 24 were re-instated, and 32 awarded reciprocal registration. Twenty were awarded temporary registration. Records show an increase in student enrolment in most of the schools of nursing. Reports from the five chapters showed regular meetings being held with varied and interesting programs. Contributions are being made to the War Memorial Fund, British Nurses Relief Fund, and the Rest-Breaks Home.

Miss Isabel Lane, convener of the Legislation Committee, presented a progress report on the revision of the Act of Incorporation and By-laws. Reports were heard from the following committees: Labor relations, health insurance, *The Canadian Nurse*, the Maritime Hospital Association, publicity, subsidiary nurse, and the War Memorial Fund.

The speaker at the afternoon session was Miss Winnifred Cooke, her subject being "The Challenge We Are Facing Today." The meeting adjourned for tea when the members were guests of the Saint John Chapter.

Mrs. E. T. K. Mooney gave a report on the I.C.N. Congress and told of the many educational and interesting sessions.

On Wednesday evening a banquet was held in the hotel ballroom with Judge L. M. Pepperdene, of the Saint John Juvenile Court, as guest speaker, taking as his subject, "On Being Misunderstood." He pointed out that most of the troubles of children and adults arise from being misunderstood.

On Thursday morning the committees on Institutional, Public Health, and Private Duty Nursing met concurrently and later presented their reports. The Committee on Institutional Nursing submitted a resolution requesting an institute for instructors of nurses throughout the province in Saint John. The chief topic to be discussed at this institute would be the compilation of a minimum curriculum for New Brunswick with a view to starting first-year examinations.

A resolution from the Committee on Private Duty, which proposed that a nurse be entitled to charge $2.00 per day over the regulation fee for each additional patient, total fees not to be more that $3.00 over the regulation fee, irrespective of the number of patients, was approved by the meeting.

A panel discussion on "The Correlation of Hospital and Community Services" was conducted by the Saint John Chapter, with Miss K. Bell as chairman. Agencies represented were: the General Hospital; the Tuberculosis Clinic; school nursing; child welfare; Victorian Order of Nurses and Family Welfare Association. It showed very clearly the method of working through these agencies. Educational exhibits were on display from Fredericton and St. Stephen Chapters.

The meeting adjourned for luncheon when the members were again guests of the Saint John Chapter. An invitation to hold the 1948 annual meeting in Fredericton was accepted.

ALMA F. LAW
Executive Secretary, N.B.A.R.N.

STUDENT NURSES PAGE

Chronic Nephritis

JEAN SUTHERLAND

MAVIS was admitted to the hospital by wheel-chair on February 10 at 6:15 p.m. She looked very ill, was breathing with great difficulty, and was slightly cyanosed. Her temperature was 96°, pulse 100, weak and irregular, respirations 40. She had a short dry cough and complained of frequent sore throats. Her abdomen was distended and legs and feet edematous. A bowel movement a few minutes after admission contained stool of a green liquid consistency and appeared to contain some mucus.

Physical examination was performed by Dr. M and his findings were: enlarged heart, congested lungs with orthopnea, edema of feet and legs, and anemia. His diagnosis was chronic nephritis. Nephritis is a term which implies much more than mere inflammation of the kidneys. We do see kidneys which are definitely infected and, therefore, inflamed but their condition is quite different. In nephritis no organism can be demonstrated in the renal tissues, though it is believed that their presence or the presence of their toxins in the kidney at some previous time may have been followed by local tissue responses producing the pathologic picture of nephritis.

The symptoms of chronic nephritis are variable. Some patients with severe grades of this disease have no symptoms at all for a long time. They may discover their condition as the result of an application for life insurance when the blood pressure is found elevated. Or it may be suggested during a routine eye examination, when vascular changes or hemorrhages are found. The first intimation others have is a sudden severe nose-bleed, a stroke, paralysis, or uremic convulsions. Most patients merely notice that their feet are swollen at night while others may have severe symptoms suggesting heart or blood vessel disturbance but no renal disorder. Still others have marked renal insufficiency. The majority of all patients also have general symptoms such as loss of weight and strength, increasing irritability and nocturia. Headaches, dizziness, and digestive disturbances are common.

If we were to examine these patients closely it is likely that the heart would be found considerably enlarged, the arteries sclerotic and tortuous, and the blood pressure high. Later in the disease these patients do not "feel well," they lose weight and strength, they have severe headaches, shortness of breath and dyspnea which might suggest bronchial asthma. Later still may appear Cheyne-Stokes respiration and the symptoms of chronic congestion of the gastro-intestinal canal. Various grades of edema develop. They complain of black spots before their eyes, flashes of light, dimness of vision and transitory blindness. On examination, arterial changes of the retinal arteries are seen, also retinal hemorrhages and exudates and edema of the discs. The skin is dry with a tendency to eczema and pruritus (itching of the skin). Later,

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Miss Sutherland is a student nurse at the Misericordia Hospital, Edmonton, Alta.

cardiac edema, often confused with venal edema, and the symptoms of uremia appear.

Another important symptom is polyuria, frequent micturition particularly at night, and also a fixation of a specific gravity of the urine, that is, their urine does not show the normal variability of concentration, due to what they eat, drink or do, but regardless of the patient's activities is all of practically the same composition. If the urine has a specific gravity of 1.010 or less day after day, a diagnosis of this condition may be safely made with or without the presence of albumin. Occasionally red blood cells appear in the urine.

In chronic nephritis the dietary treatment must be adjusted from time to time as the disease progresses. Because of the great reserve power of the kidney no special restrictions need be made in the early stages. Although there is no known cure, dieting or otherwise, it is important to maintain the body in the best possible condition and so prolong life. The diet should be ample for maintaining normal body weight. Protein should be adequate (50-70 grams) but not excessive. Salt is restricted slightly and water also in proportion to the degree of edema. Fats are limited to the more easily digested forms with no fried foods or rich pastries served. Carbohydrates may then be increased to make up the normal caloric requirement. Overeating must also be avoided.

When edema becomes a serious problem the diet must be adjusted by restricting fluids and salt. When edema is accompanied by the secretion of large amounts of albumin, the protein must be increased to higher levels to make up the deficit. If, during the course of the disease, there is nitrogen retention in the blood, the food protein may be lowered temporarily. The protein food needs to be balanced against the level of non-protein nitrogen (waste products) in the blood.

In the so-called "nephritic stage" of chronic nephritis, the patients present a striking picture. The skin has a pale pasty appearance; often the whole body, almost always the face, lower extremities, and dependent parts of the body are swollen with edema. The eyes are almost closed by puffed lids, edema of the retina may interfere with vision, the lips appear twice their normal sizes. Fluids collect also in the abdominal cavity (ascites) which greatly distends the abdomen. The patient is short of breath and must sit upright (orthopnea). Water may collect in the pericardial sac and the patient is short of breath, cyanotic, and the pulse is weak.

Patients suffering from nephritis usually die of uremia. In uremia the patient is very drowsy, complains of headache, vomiting, restlessness, mental wandering, and foul breath. They become increasingly drowsy, respiration becomes Cheyne-Stokes in character, a deep coma develops, often accompanied by convulsions. Death soon follows.

Mavis had her first attack of illness when she was three years of age. She was admitted to the hospital with symptoms of nausea and vomiting, headache, sore throat, high fever, and convulsion. She was bothered with nocturia and frequent micturition. The symptoms finally subsided and she had a tonsillectomy before leaving the hospital. The specimen of urine examined while she was in the hospital must have contained albumin because it was then that the doctor told her mother that Mavis had a kidney disorder.

It was not until Mavis was fifteen years old that she became ill again. She was admitted to the hospital with influenza. She lost her sight for a short while. Her blood pressure was high. An x-ray was taken of her kidneys and they found that she had only one in function.

Until November of the following year, Mavis enjoyed good health. Then she took influenza again, this attack being more severe than the one before. She complained of nausea and vomiting, running ears, headache, sore throat, high fever, nose-bleeds, and difficult breathing. Her lungs were congested. From then until she was admitted on February 10, the symptoms did not entirely subside. That night, Mavis slept very little due to nose-bleeds, dyspnea, and general malaise. Nembutal gr. 1½ was ordered but this had very little effect. The next day her condition was unchanged. Her diet consisted mostly of citrus fruit juices and she took very little of these.

On the night of February 11, she became irrational, often crying out in the night. It was also noticed that night that her left eyelid and the left corner of her mouth had dropped. Her mother reported that the left side of her face had been paralyzed for a short time the year before. On the next day and night she was still irrational. She began to have involuntary micturition and defecation. Often she would not void for ten or twelve hours, then would void as much as thirty ounces at one time. Her blood pressure taken on February 12 was 210/170. Normal blood pressure at her age is 110-130/70-90.

On February 13 her skin was becoming noticeably yellow in color. During the next five days her symptoms became progressively worse until on February 18 her urine had become a dark red and she also had emesis of a dark substance. She was by this time in a state of semi-coma.

The next day, she had a convulsion, was in a coma, and her respirations were Cheyne-Stokes in character. She was rather restless at times that afternoon and that evening she expired.

Non-protein nitrogen: The function of the kidneys is to remove from the blood certain of the waste products of cellular activity. Any degree of accumulation of these particular products in the blood is a measure of the inadequacy of kidney function. The substances chosen for this purpose are the nitrogen-containing products of protein combustion, their amounts estimated in terms of the nitrogen theory. Normally, the amount of total non-protein nitrogen in blood obtained from a vein 14 hours after the last meal varies from 25 to 40 milligrams per 100 cubic centimetres. In nephritis there is a definite rise in non-protein nitrogen. Mavis' report was 300 mgm. per 100 cc. of blood.

Blood urea: Of the total 25 to 40 milligrams of the normal non-protein nitrogen, 12 to 15 milligrams consist of urea nitrogen. Mavis' urea nitrogen was 200 mgm. per 100 cc. of blood.

Specific gravity: By this is meant the ratio between the weight of a given volume of urine to that of the same volume of water. Normally specific gravity is 1.015 to 1.020. If 1.010 or less the case is usually one of chronic nephritis. Mavis' report was negative on the last day.

Albumin: Normal renal cells allow a trace of albumin to pass into the urine but this trace is so minute that it cannot be detected by the ordinary tests. If any at all can be recognized by these tests an albuminuria is present and indicates pathology.

Nursing problems encountered: Because the patient had orthopnea, she was kept sitting up in bed at all times, thus putting all the weight and pressure onto her buttocks which soon became very red and sore and gradually developed bedsores. Very special attention had to be given to her buttocks. Incontinence of urine and feces did not help any. She had to be kept clean and dry. Buttocks paste, zinc oxide, and antiseptic powder were all used. An air-ring was used to help relieve the pressure.

Because she breathed through her mouth all the time her lips soon became dry and cracked. Application of lemon and glycerine and boracic ointment helped to combat this. Special attention was given her mouth. Her breath was very foul so hydrogen peroxide mouth-washes were given.

Oxygen was established whenever a sitting-up position did not relieve the dyspnea.

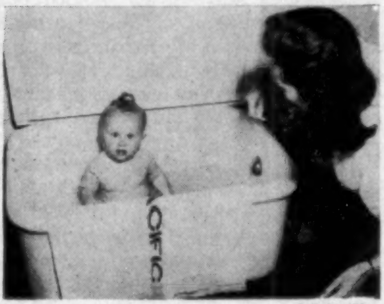
The face had to be bathed frequently because, before she went into a coma, she had scratched her face causing bleeding sores and scratches. Daily baths, so important to nephritic patients, were also necessary.

Prognosis of nephritis is very poor. The patient must be careful to observe all health rules and take every precaution to avoid colds or any communicable disease. He must consult his doctor regularly and should not take patent medicines, such as kidney pills, without the doctor's permission.

Any man who repeats half of what he hears, talks too much.

Helping Mothers

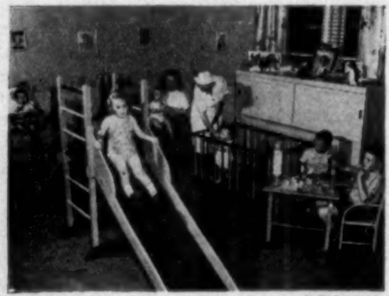
A wait between trains in a strange city, with a couple of children in tow, is a prospect grim enough to appal the most competent young mother, but from now on such stopovers in Windsor Station, Montreal, will, instead, give both parent and youngster a chance to rest, relax, and freshen up before continuing their journey.



C.P.R. Photo

Enjoying a bath

For the use of mothers passing through Montreal with young children, the Canadian Pacific has opened a three-room nursery off the main concourse. In charge of a trained matron, the nursery might be said to have a noisy room and a quiet room. The former is equipped with an indoor slide, blocks, toys and other paraphenalia, where the kiddies can be turned loose to have fun. The latter has cots for the children to sleep and chairs for their mothers to relax.



C.P.R. Photo

Youngsters have fun in playroom

Two diminutive tubs are provided in the bathroom for the very necessary business of the regular bath, and a hot plate, bottle-warmer, and sterilizer are available for preparing milk and formulas. All of the nursery's rooms are decorated with pictures and "transfers" of animals and children.

One of the nursery's first "customers" was a young lady making the long journey from Timmins, in northern Ontario, to show her 14-month-old boy to her parents in Yarmouth, N.S. Although she claimed that she had dreaded the thought of the wait between trains, it wasn't long before both mother and child were having the time of their lives.

C.P.R. Photo

The nurse warms a bottle for a very young traveller

Miss Ethel Alexander, R.N., is matron-in-charge, and will gladly keep an eye on the children while a mother sees about tickets or has a meal in the station restaurant. Miss Alexander is a graduate of the Children's Memorial Hospital, studied post-graduate work in child welfare in New York, and before joining the C.P.R. was for several years with the Child Welfare Association.

When the baby is two weeks old, give 15 drops of orange juice each day; increase this every day 15 drops until 2 tablespoonsful are being given. When tomato juice is used, give double the quantity.

— Ernest Couture, M.D.

Book Reviews

Materia Medica for Nurses, by Lois Oakes, S.R.N., D.N. and Arnold Bennett, M.P.S. 354 pages. Published by E. & S. Livingstone Ltd., Edinburgh. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 2nd Ed. 1947. Price $1.75.

Reviewed by Sister Mary Irene, Instructor of Nursing, Charlottetown Hospital, P.E.I.

Now in its second edition, this well-known English text has been brought up-to-date by the addition of new material dealing with the sulfonamides and penicillin. The entire content of the book has been revised and rearranged. In doing this the authors have kept in mind the needs of the nurse and have succeeded in providing a readable and extensive account of the principle drugs in common use.

The book is divided into twelve chapters which follow each other in logical order. The introductory unit on the Medicine Cupboard and its Care is of practical value to instructors as well as to student nurses. In the following chapter, the Imperial and Apothecary Systems are discussed in detail and their relationships to the Metric System are clearly indicated. One chapter which is worthy of special mention deals with the common drugs classified according to their therapeutic action, simplifying the learning process for the student nurse.

This book is well worthwhile for the school of nursing either as reference or as a text.

Tuberculosis Nursing, by Grace M. Longhurst, R.N., with the collaboration of N. S. Lincoln, M.D. and R. Douglas, M.D. 358 pages. Published by F. A. Davis Co., 1914 Cherry St., Philadelphia 3, Pa. 2nd Ed. 1947. Illustrated. Price (in U.S.A.) $3.50.

Reviewed by Esther Paulson, Nursing Supervisor, Division of Tuberculosis Control, Department of Health and Welfare, Vancouver.

One's first impression of this revised edition on tuberculosis nursing is its importance to nurses, old as well as new, in service to this branch of nursing. For that reason, individuals representing these groups were asked to contribute their viewpoints.

Miss Bess Macpherson writes: "From one who has nursed during the old, through the transition stage to the present day it is a revelation to read of the change in trends of thought toward the disease due to mass surveys, and the increased scope in tuberculosis nursing resulting from the broader field of service to the patient. The stress on education of patient and family indicates the need for special preparation, a contrast to the day when tuberculosis nursing was regarded merely as routine bedside care."

Miss M. Hope Hewett, impressed by the comparison of this book with the 1944 edition, writes: "Slight differences in Unit and Chapter headings and contents illustrate advanced thinking, signified by the shift of emphasis from physical nursing to the nurse-patient relationship implying intelligent patient participation. Behavior problems are considered within the scope of nursing in the hospital."

Illustrative case histories help the nurse toward an understanding of the patient as an individual. Co-operation is the keynote of the book, as it is of the whole tuberculosis program embodying the aims of education, prevention, cure, and rehabilitation.

Dr. G. F. Kincade and Dr. G. E. Saxton, in reviewing the medical and surgical sections, were well impressed with the value of the book and consider the section on surgery indicative of a thorough understanding of the modern concept of surgical treatment. It is sufficiently lucid and well illustrated to be instructive to nurses in this field.

The object of this book is to convey the aims of modern tuberculosis nursing and how to accomplish them, including those intangible aspects which are the very core of a good nursing service in a tuberculosis program.

The Care of the Child, by Alton Goldbloom, M.D. 308 pages. Published by Longmans, Green & Co., 215 Victoria St., Toronto 1. 4th Ed., revised and enlarged. 1946. Price $2.00.

Reviewed by Katherine Barr, Assistant Director, City Health Department, Winnipeg.

In the last fifty years the efforts of scientists and educators have contributed immeasurably to our understanding of children. The child is no longer considered a miniature adult but in his own right an individual whose needs—physical, intellectual, emotional, and

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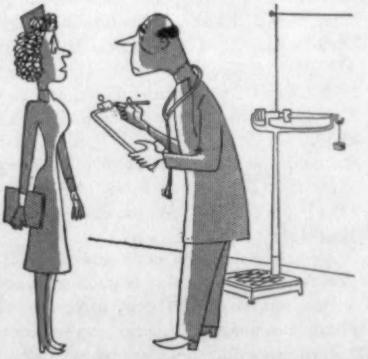
"Finger on the PULSE"

Try try again — Not easily discouraged, optimist Mrs. Betty Dunlavy, 40, of Brooks, Ore., still hoped the "right man" would come along. She made this statement while suing for her 15th divorce.

Just horse sense: Down one of Montreal's busiest streets galloped the runaway horse. People jumped for safety as he madly dashed through two green lights. Then suddenly at the third intersection he came to a dead halt—the light was red!

The hard way: It happened in Newcastle, Australia, where a 70-year old woman refused to press charges against a man who hit her over the head with an axe handle. Her reason: The blow improved her eyesight and brought her blood pressure, high for years, down to normal.

Timely hint: No more smoking was the answer of George Smythe of Ipswich to a rise in cigarette tax. Instead, he invested the money in football pools. You guessed it! His winnings—$94,790.00



"The new interne said I'm obnoxious, doctor! Is that curable?"

social — must be adequately met if he is to become a happy citizen of our democratic society.

This book presents in simple style the interpretation and application of many of these newer concepts of child growth, development, and care. Throughout, it has been the author's aim to keep in mind the many and varied questions asked over a period of years by perplexed parents in the bringing up of their normal children.

Beginning with a short discussion of prenatal care, insofar as it concerns the health of the unborn infant, and concluding with the much discussed topics of adolescence and sex education, the intervening chapters take the baby and his family from the first days of his life through feeding schedules and weaning, habit training and discipline, minor illnesses, infectious diseases and immunization procedures. Care has been taken at each step of the way to clarify those points which worry parents most.

The fact that this appears as the fourth edition of a book first published in 1928 by a leading Canadian pediatrician speaks well for its popularity. Although designed to guide parents it should prove helpful to the public health nurse in providing her with those talking points so essential in home, school, and community.

Careers for Nurses, by Dorothy Deming, R.N. 358 pages. Published by The McGraw-Hill Book Co., 330 West 42nd St., New York 18. 1947. Illustrated. Price (in U.S.A.) $3.50.

Reviewed by Elizabeth Braund, Director, Placement Service, Vancouver, B.C.

The purpose of Miss Deming's book is to help nurses to choose the branch of nursing which will provide them with the maximum of "job satisfaction." Before describing a variety of nursing positions, Miss Deming gives a splendid outline of all aspects of a position which should be considered before submitting an application. The discussion of terms of employment, interview procedure, and the letter of application is particularly fine.

To stress the multiple branches of nursing, Miss Deming has had eighteen nurses tell of their own positions. Because each writer has an individual style and an individual method of dealing with her subject, the book possesses variety and freshness. The reader is made most aware of each contributor's enthusiasm for her own particular work.

Information on salary ranges and sources of employment is included after the description of each position. Bibliographies appear at the end of all chapters as well as at the end of the book.

Instructors will undoubtedly wish to recommend "Careers for Nurses" to their senior students. When planning their professional future, all graduate nurses will find that the book is a very useful guide.

℞ Chuckles P.R.N.

Note: Over a period of years, every instructor in our schools of nursing garners a few choice "boners" made by her students. Some of these have already been shared with us and we will pass them on to you each month through this column. Bright remarks of children will also be fodder for ℞ Chuckles P.R.N. Send us your stories or boners. Here are some for a start:

A contact is one who has been in the company of disease germs.

Pernicious vomiting is no joke nor should it be treated as such. Neither is it considered neuritis.

The ileum is part of the hip-bone or, if you prefer, a part of the intestines.

The value of having your R.N. is to distinguish nurses from other types of frauds.

When a person has to sit up in order to breathe, they are said to have dysentery.

The incubation period is the period which a mother spends at the hospital under observation before her child is born.

Prepayment Health Plan

The past ten years has witnessed a remarkable growth in the total membership enrolled in Blue Cross prepaid hospitalization plans in Canada and the United States, according to figures included in the 1947 *Facts about Nursing* published by the Nursing Information Bureau of the American Nurses' Association. Their findings are based upon figures released by the American Hospital Association Blue Cross Commission.

Year	*Total Membership*
1947	25,876,424
1946	19,989,205
1945	16,511,198
1944	13,005,493
1943	10,458,899
1942	8,456,267
1941	6,049,222
1940	4,431,772
1939	2,874,055
1938	1,364,975
1937	608,021

1947 INDEX

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M.L.I.C. Nursing Service

The following is information concerning the Nursing Service of the Metropolitan Life Insurance Company:

Appointments: *Gilberte Cantin* (Ste. Justine Hospital, Montreal, and University of Montreal public health course) to Montreal.

Transfers: *Simonne Cadieux* (Sacred Heart Hospital, Hull) from Montreal to Quebec; *Jeanne d'Arc Hamel* (St. Sacrement Hospital, Quebec, and University of Montreal public health course) from Montreal to Three Rivers; *Eugenie Tremblay* (Notre Dame Hospital, Montreal, and University of Montreal public health course), formerly at St. Jerome, to Quebec.

Ontario

The following are staff changes in the Ontario Public Health Nursing Service:

Following a leave of absence for study at Teachers College, Columbia University, *Pearl Stiver* (Toronto Western Hospital and University of Toronto certificate course) has returned as supervisor of venereal disease nursing with the Ontario Department of Health. She has been granted the degree of Bachelor of Science in Nursing.

Appointments: *Annie Carson* (Welland County General Hospital and Approved School Nurse course, Ontario Department of Education) to Board of Health of the Village of Ayr and the Townships of North Dumfries and Wilmot; *Leah Lowe* (University of Toronto diploma course) to Barrie Board of Education; *Mrs. Betty Brown* (Victoria Hospital, London, and University of Western Ontario certificate course) to Owen Sound Board of Health; *Beryl Williams* (Women's College Hospital, Toronto, and University of Toronto certificate course), formerly with Northumberland and Durham health unit, and *Mrs. Mary McPherson* (Johns Hopkins Hospital, Baltimore, Maryland, and Approved School Nurse course, Ontario Department of Education), formerly with Owen Sound Board of Health, to Oshawa Board of Health; *Doris Smith* (Health Visitor, Royal College of Nursing, London, Eng.) to Elgin-St. Thomas health unit.

Resignations: *Kathleen Lyne* (Hospital for Sick Children and University of Western Ontario certificate course) from Galt Board of Health; *Mary Murdoch* (Saint John General Hospital, N.B., and University of Toronto certificate course) from Welland and district health unit; *Marion Thompson* (Toronto General Hospital and University of Toronto certificate course) as senior public health nurse with Windsor Board of Health;

Marion Monck (Hamilton General Hospital and University of Western Ontario certificate course) from Bruce County health unit; *Dorothy Coke* (Victoria Hospital, London, and University of Western Ontario certificate course) from Lambton health unit; *Eleanor (Fendley) McComb* (Saskatoon City Hospital and University of Western Ontario certificate course) from Oxford County health unit.

Victorian Order of Nurses

The following is information concerning staff changes with the Victorian Order of Nurses for Canada:

Appointments: *Laura Bowen* (Kingston General Hospital and University of Toronto public health course), Montreal; *Doreen Gifford* (Royal Jubilee Hospital, Victoria, and University of Toronto public health course), Victoria; *Elizabeth Nelder* (Ottawa Civic Hospital and University of Toronto public health course) and *Pauline Sacks* (University of Toronto School of Nursing), Toronto; *Rita McIsaac* (University of Ottawa School of Nursing), Ottawa.

Transfers: *Elizabeth Hicks* from Porcupine to be nurse-in-charge at Oshawa; *Gladys Doran* from York Township to be nurse-in-charge at Cobalt; *Elizabeth Berryhill* from Sarnia to be nurse-in-charge at Collingwood; *Claire Hicks* from Windsor to be nurse-in-charge at Aurora.

Resignations: *Margaret Lownds* from Halifax, *Margaret Forry* from Elphinstone and *Betty Brown* from Collingwood, all to be married; *Christine Lund* from Vancouver; *Velma Martin, Sarah Hamilton, Hilda Tackaberry, Ruth (Summers) Abel*, and *Iva Curry* from Toronto, the latter to take up other work.

V.O.N. scholarships, for the purpose of assisting nurses to take the university course in public health nursing, have been awarded to the following who are attending the universities indicated: University of Toronto: *Phyllis Paisley* (Toronto Western Hospital); University of Western Ontario: *Patricia Marks* (Victoria Hospital, London); McGill University: *Margaret Hollenbeck* (Montreal General Hospital).

The Nurse's Response

The nurse's own emotional reactions to general and specific nursing situations is important. We can take it for granted that the nurse does respond emotionally since she is a human being. We know also that her emotional response is not only inevitable but desirable since without it she would move as an automaton. We dare, in our present interpretation of relationships, to be normally warm and outgoing with our patients to the degree that is natural for each of us as individuals. We legitimately expect to enjoy ourselves — most of the time — in our work. However, we also recognize that we are not only human beings but professional human beings with responsibility, therefore, for being aware of our own emotional reactions, as far as this is possible, and the way in which these motivate and influence our methods of work, our standards, and our attitudes toward other people, especially toward patients.

— RUTH GILBERT, R.N.

in *Public Health Nursing, November, 1947.*

A pair of substantial mammary glands have the advantage over the two hemispheres of the most learned professor's brain, in the art of compounding a nutritive fluid for infants.

— OLIVER WENDELL HOLMES, M.D.

Nursing Sisters' Association

May we extend to all the Nursing Sisters' Units across Canada our sincere good wishes for the New Year. During 1948 let us resolve to exert our efforts and increase our contributions to help the less fortunate nurses in devastated countries and so, working together, strive to promote peace and international understanding.

Your national executive is looking forward to the biennial meeting in June when the Saint John Unit will be hostess to all the units across Canada. Letters will go forward to each one regarding the exact dates, etc. We hope plans are already being made by members to join us in Sackville, N.B.

MARY EDGECOMBE
President

Sara Miles, A.R.R.C., has been appointed chairman of the Rehabilitation Committee. Further contributions to the fund are: Hamilton Unit, $250; Montreal Unit, $100;

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or

Miss F. Munroe, R.N., Superintendent of Nurses, Royal Victoria Hospital, Montreal 2, P. Q.

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For further particulars apply to:

Superintendent of Nurses, Toronto Hospital, Weston, Ontario.

Edmonton unit, $18.50. The total to date is $3,418.50.

Five hundred dollars has been voted by the N.S.A.C. to the C.N.A. War Memorial Fund.

Last year was an active and busy one for the *Edmonton Unit* when the annual tea netted $150. This money is used each month for comforts and birthday presents for the patients at the Newburn Pavilion at Government House and the Charles Camsell Hospital. The unit became a corporate member of the United Nations Society and a representative attends each monthly meeting of the society. Last June the president, Mrs. Arnold Taylor, was invited to the opening of the Provincial Legion. In July a reception was held for General Faukes at the United Services Club (Military Institute). Uniforms and clothing were sent to overseas nurses.

At the October meeting clothes, toys, and books were collected and taken to the Ex-Servicemen's Children's Home for distribution. In November an Armistice Remembrance was given to all D.V.A. patients in hospital. The money was collected by a contribution from each member. The Armistice Day reunion was held in December.

Several nursing sisters of the *Halifax Unit* attended the Memorial Services held in May. Fifty sisters were also present at a successful tea and get-together held in June. Five boxes of used uniforms and aprons were shipped to European nurses and letters of thanks were received from Roline Van Voorthuysen, The Hague, and Frances Goodall, general secretary of the Royal College of Nursing in London.

On Remembrance Day a wreath was placed on the cenotaph by Lillian Fitzgerald and Matron Jean Nelson, R.R.C., of World War I. Forty-four members and two guests were present at the annual meeting and dinner held in the evening. A hearty vote of thanks was extended to Miss Fitzgerald, the retiring treasurer. Officers elected for the coming year include: Matron Jean Nelson, who was re-elected as president; secretary, Georgina Thompson (also re-elected); and treasurer, Blanche Gill. Mrs. Jean (Mitchell) Cott, World War I, now living in Australia, expressed pleasure at being back in Nova Scotia and meeting many of her old friends. B. Buff was at the piano for the sing-song that followed.

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The *Hamilton Unit* has a membership of fifty-two. At the annual meeting forty-two were present when E. Ewart was elected as president with D. Parsons as secretary-treasurer. A tea was held in April when the members attending the R.N.A.O. convention were entertained. Two hundred and fifty dollars was raised from a raffle. This sum was contributed to the Rehabilitation Fund. The annual dinner was held in November.

The *Regina Unit* was inactive during 1947 with the exception of the placing of a spray of lilies on Decoration Day at the cemetery. The members attended the Memorial Services held in May. At a social gathering held at the home of the president on her departure for Vancouver, Mrs. Shand was presented with a gift. She is one of the original members of the unit.

Forty-seven members of the *Saint John Unit* were present at the Remembrance Day dinner. The president, A. Burns, presided, and with her at the head table were Mrs. G. E. Barbour, honorary president, and members of the executive, as well as the national president, Mary Edgecombe. Mrs. Agnes Sutherland, R.R.C., was a special guest.

A successful rummage sale was held to augment the unit funds.

The officers serving at present include: Ina Wetmore, president; Cora DeWolfe, secretary; Mrs. Beverly Howard, corresponding secretary; Mrs. John MacCoubrey, treasurer.

Two hundred and seventy nursing sisters, representative of both world wars, attended the Remembrance Day dinner held by the *Toronto Unit*. The president, Ethel Greenwood, presided, and in the absence of Mrs. Helen Howe the arrangements were in charge of Mrs. Harry Coles, assisted by Betty Wright and Margaret Kennedy. At the head table were the president, immediate past president. Mrs. Gilbert Storey, first vice-president, Col, Agnes Neill, matron-in-chief, World War II, second vice-president, Jean Taylor, and a large group of matrons of both wars.

A specially honored guest was Elizabeth Russell, the only Canadian nurse who served in four wars — the Boer War, Spanish-American, the Philippines, and matron in World War I.

Special mention was made of Mrs. LeRoy Cody's splendid work as convener of the Membership Committee and also as ticket

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and telephone convener. Credit was given to Mrs. Roy Adams Carroll who took charge of Poppy Day. The largest amount ever collected by the unit, over $900, was received.

Dr. J. Markowitz, O.B.E., was guest speaker, and he gave an excellent account of experiences as "Doctor in a Prisoner-of-War Camp."

Seventeen members were present at the Remembrance Day dinner held by the *Windsor (Ont.) Unit.* There were nine representatives from World War I and eight from World War II. In the absence of the president, Nellie Gerard, the vice-president, Mrs. Jack Kent, presided. A social evening followed the dinner.

News Notes

BRITISH COLUMBIA

GREATER VANCOUVER DISTRICT ASSOCIATION:

Gertrude Hall, general secretary, Canadian Nurses' Association, was the guest of honor when the president, Janie Jamieson, and members of the executive of the Greater Vancouver District Association, R.N.A.B.C., entertained at tea at the Hotel Georgia. The executive members include: Mrs. L. Grundy, president, Vancouver Chapter; Mrs. A. Beach, president, West Vancouver Chapter; Mrs. M. Mitchell, president, North Vancouver Chapter; P. Capelle, C. Charters, Mmes G. Shugg, L. E. Jones, Watson, Sr. Priscilla Marie.

Invited guests included: Dean D. Mawdsley, University of B.C.; E. Mallory, president, and E. Paulson, first vice-president, R.N.A.B.C.; A. Wright, registrar, R.N.A.B.C.; B. Simpson, president, Student Council, Vancouver General Hospital School of Nursing; L. Richardson, president, Student Council, St. Paul's Hospital School of Nursing; Miss Chalmers, vice-president, Student Council, Royal Columbian Hospital School of Nursing; M. Roddan, president, Student Nurses Association of B.C.; Sr. Columkille, director of nursing, St. Paul's Hospital; E. Palliser, director of nursing, Vancouver General Hospital; K. Panton, matron, Shaughnessy Hospital; E. Clark, superintendent of nurses, Royal Columbian Hospital; E. Erskine, superintendent of nurses, Children's Hospital; K. Lee, superintendent of nurses, North Vancouver General Hospital; R. Walker, superintendent, Preventorium; Mrs. A. Wyness, president, Science Girls Club; Mrs. G. Bakkan, president, Vancouver General Hospital School of Nursing Alumnae; Mrs. J. W. Lane, president, St. Paul's School of Nursing

Alumnae; S. Norman, president, Catholic Nurses Guild; E. Pullan, chairman, Instructors' Committee; M. Parsons, director of nurses, Provincial Mental Hospital, Essondale; D. Jack, supervisor, Outpost Hospitals; Mrs. F. DeSatge, Nursing Division, Red Cross; Mrs. Kellington, president, Royal Columbian School of Nursing Alumnae; Miss Bews, president, New Westminster Chapter, R.N.A.B.C.; J. Walter, senior instructor, Vancouver General Hospital; Miss Wahl, senior instructor, St. Paul's Hospital; Mrs. E. Pringle, inspector of hospitals and institutions; T. Hunter, Metropolitan Health Unit; Miss Creasor, V.O.N.; A. Cavers; N. Armstrong; Miss Morrison and E. McCann, Department of Nursing and Health, University of B.C.; E. Braund, director, Placement Service, R.N.A.B.C.

In the evening Miss Hall was guest speaker at the semi-annual meeting of the association when her topic was "Charting a Course in Nursing." Her address was heard with interest by the members since it dealt with all phases of nursing and its responsibilities as interpreted today.

ROSSLAND:

Approximately sixteen members were present at a recent meeting of Rossland Chapter, R.N.A.B.C., when plans were made to help in the T.B. Chest Clinic survey. Mmes R. Thompson and W.C. Stevens are to assist with the Blood Bank Clinic. Members listened to the broadcast of the inauguration of the public health unit in this district when Dr. J. S. Daly, of Trail, and the four health nurses of this district — F. A. Kennedy, Kay Comeford, Jessie Urie, and Evelyn Tier — explained the purposes of the unit. Miss McLean read several articles from the Nurses' Bulletin and a report of the district meeting was also given.

F. A. Kennedy was the winner of the ad contest, when Mrs. L. E. E. Hamilton presented her with her prize, consisting of a suitcase full of kitchen utensils. Since Miss Kennedy is "batching" it this year the members thought they would like to help furnish her kitchen. Refreshments were served by Mmes A. Wood and W. K. Scatchard.

Mrs. J. Osborne was welcomed as a new member at a later meeting, when F. A. Kennedy was in the chair. Miss McLean, who is the West Kootenay councillor on the provincial executive of the R.N.A.B.C., gave a short resume on the coming changes in the district and chapter by-laws and explained the changes in the boundary of the district. Mrs. A. McAllister, Jr., is being assisted by members in giving lessons and lectures in the Red Cross nursing classes. A report was heard on the hospital dance, the proceeds of which will be used to purchase bassinettes for the hospital.

Mrs. T. B. McMillan, the guest speaker, gave an address on India, telling of the hospital and medical work in that country. She illustrated her talk with the use of maps and pictures.

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NURSING

By Lulu K. Wolf, Professor of Nursing, Vanderbilt University School of Nursing. This new nursing textbook deals not only with bedside nursing techniques, but with rehabilitating the patient after illness. 534 pages. 201 illustrations. 1947. $4.00.

INFECTIOUS DISEASES

By A. B. Christie, Medical Superintendent of the City Hospital, Liverpool, England. This new British book deals very thoroughly with the clinical side and the nursing techniques of infectious diseases; and also with the wider aspects of control and management. There are chapters on carriers, food-handlers, infections of young infants and special chapters on venereal diseases. 324 pages. Illustrated. 1947. $3.75.

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Ottawa.

Mrs. E. Leduc and F. McLean, as hostesses, served refreshments assisted by Mmes Scatchard and Comesotti. Eleven members were present.

VANCOUVER:

St. Paul's Hospital:

The December alumnae association meeting took the form of a Christmas party when everyone brought a gift for the tree. An alumnae tea and sale of goods was also held when a feature was the novelty booth. There was also a great variety of candy canes for sale. In the raffle held by the alumnae the winners were Mr. A. Malcolm, Miss W. Turner, and Dr. E. Stevenson.

Dr. J. Frost was the winner of the Labrador puppy raffled at the Dog Show which was most successful. More than one hundred dogs were entered. The thanks of the alumnae go to Mrs. McKenzie and Miss Cronkite and others for all the work they put into this effort.

MANITOBA

At a meeting of the Brandon Association of Graduate Nurses, Mrs. Aleta Grant addressed the members on "Music." She described the various types of music being sung by her pupils, several of whom took part in the demonstration. Jean Wilkie introduced Mrs. Grant and pupils while Mrs. E. Griffin expressed the thanks of the members. The president, M. Patterson, was in the chair.

The association, particularly the married nurses' section, will miss a faithful member, Mrs. W. A. Peirson, who has gone to live in Winnipeg. Mrs. Peirson (Benvenuta Nutman), a graduate of the class of 1909 of the Brandon General Hospital, served with the Q.A.I.M.N.S. in England and Malta during World War I.

NEW BRUNSWICK

SAINT JOHN:

The Saint John Chapter, N.B.A.R.N., held a regular meeting with Miss Downing, the president, in the chair. The Lancaster Hospital Association reported that a successful "pound" party was held, the food received being sent overseas to British nurses. A "Bring and Buy" sale was conducted with Bea Selfridge as auctioneer. The sum obtained from this sale brought New Brunswick "over the top" in the War Memorial Fund campaign. Five dollars was donated to the Children's Aid Society.

Atlanta Sollows was the guest speaker and her entertaining talk on "Shell-Fish and the Way They Live" was much enjoyed. The members were interested in seeing samples of her shell-work.

A meeting of the Public Health Section, Saint John Chapter, took the form of a supper party, when D. Fullerton, the president, was in the chair. Miss Fullerton announced the continuance of the practice of each nurse forwarding a gift box to a nurse in London.

Miss Peden, the district social service superintendent for the D.V.A., was the guest speaker. She told of the general services available for veterans and outlined the various legislation relative to pensions, allowance, etc. She also stressed the necessity for co-operation with other existing social agencies.

General Hospital:

V. M. Siddall has joined the obstetrical department staff. Three recent graduates have been appointed as follows: Ruth Chisholm, outdoor department; Ardyth Saunders, operating-room staff; Helen Hoyt, assistant night supervisor. Joyce Small and Norma Nugent have resigned from the outdoor department and are doing general duty at Presbyterian Hospital, New York.

Miss Justason is operating-room supervisor at Saint John Tuberculosis Hospital. Ida Slipp is with the Chipman Memorial Hospital, St. Stephen. Alda Britton and Jean Bennett are doing private duty at Bourlamaque, P.Q.

ST. STEPHEN:

Twenty-three members attended a recent meeting of St. Stephen Chapter, N.B.A.R.N., when the new president, Clara Dowling, was in the chair. It was reported that remembrances have been sent to Loie Mersereau, former night supervisor at the Chipman Memorial Hospital, by her associates. Two boxes of food have been forwarded to a British nurse — one assembled by Myrtle Dunbar and the other by Reta Follis and Mrs. R. Rogers. Mmes B. O'Brien and R. Higgins served refreshments at the close of the meeting.

A party was given at the home of Mrs. R. Rogers in honor of Mrs. Edith (Phillips) Richardson, who was showered with a variety of gifts.

Betty Howard attended the meeting of nursing instructors held in Saint John. Clara Boyd has resumed her position as historian at the C.M.H.

ONTARIO

DISTRICT 1

SARNIA:

Dr. Marshall Gowland was the guest speaker at a recent meeting of District 1, R.N.A.O., when his subject was "Trends in Medical Developments in England, South Africa, and New Zealand."

DISTRICTS 2 AND 3

GODERICH:

In October, a very successful Tea and Doll Fair was held by the Community Nursing Registry of Goderich. Two doll collections of note were on display through the kindness of the owners — Mrs. L. Macklin of Stratford and Ann Wurtele of Goderich. Mrs. Macklin explained that when her collection is complete she plans to place it in the Royal

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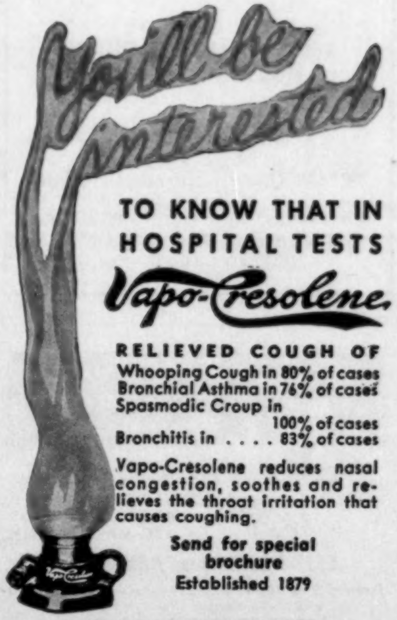

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Ontario Museum. Miss Wurtele's collection was commenced by a relative three generations ago and has remained in the family ever since.

The dolls that were for sale were dressed and donated by the Community Nursing Registry members. Unique and novel designs, calling for much work and time on the part of the members, were in evidence in the entire display but particular mention should be made of two dolls designed and dressed by the registrar of the Goderich Branch of the registry. One depicted Florence Nightingale in cap, uniform, etc., and the other was Sairey Gamp.

This was the Goderich nurses' initial attempt in a project of this nature but the interest and success of the venture was so encouraging that it is planned to make it an annual affair.

DISTRICT 4

ST. CATHARINES:

"Streptomycin" was the subject of Dr. C. G. Shaver, superintendent of the Niagara Peninsula Sanatorium, when he was the guest speaker at a well-attended meeting of the Niagara Chapter, District 4, R.N.A.O. He described this new drug, telling of its benefits in selected cases of tuberculosis. Catharine O'Farrell, the chairman, presided.

DISTRICT 9

SUDBURY:

The autumn tea, sponsored by the Sudbury Branch, District 9, R.N.A.O., proved to be a great success. The convener for this gala event was Toni Chenard, assisted by Mrs. C. Sherwood, tearoom hostess. Mrs. Jean Grey, president, Wilda McFadden, A. Walker, Ingrid Penman, M. Cliff, and Mrs. H. Moran poured tea. Mrs. Sheridan was assisted in convening the tearoom by Mmes V. Umpherson, A. Comba, Misses Cliff and E. Bertolotti. Mmes Kay Fleming and W.J. Meakes were tearoom treasurers.

Students of the St. Elizabeth School of Nursing assisted in serving the many guests. Mmes Jean Shappert and A. Delongchamps were in charge of the table displaying home-baked goods.

QUEBEC

QUEBEC CITY:

Jeffery Hale's Hospital:

Mmes L. Seale and J. Green are with the teaching department. N. MacIntosh is in charge of the out-patient department, replacing L. Eager who left the staff to do industrial nursing at Comeau Bay. Mrs. D. Jackson has replaced E. Taylor in the Douglas Ward. E. Taylor has left the staff to work with the private duty section. The following are on the general duty staff: D. Rourke, P. Ellis, H. Walsh, G. Ward, P. Allenach, J. Colton, and Mrs. P. Travers.

Lieut. (N/S) M. Doddridge is matron-in-chief at Fort Churchill Military Hospital.

USE LAVORIS As A Precaution

When colds threaten, use the best mouthwash daily

Mary Wilson is secretary to the vice-president of, and industrial nurse to the Rexall Drug Co. in Toronto.

SASKATCHEWAN

MOOSE JAW:

General Hospital:

There was a good attendance at a successful dance given by the alumnae association when Dr. L. G. Bray was master of ceremonies.

Anne Hyer has left public health nursing and is now doing general duty at Eston Hospital.

Providence Hospital:

The alumnae association held a bazaar at Castle Hall in connection with the Grace Baxter Chapter.

Rev. Sr. M. Flavian has been appointed as superintendent of nurses, replacing Rev. Sr. M. Patrice who is now in Brockville, Ont.

PRINCE ALBERT:

At a meeting of Prince Albert Chapter, S.R.N.A., the rummage sale committee turned in $22 for the Cod Liver Oil Fund. The guest speaker was Mr. Bendas who told the members "How to Conduct a Meeting."

A Christmas party was held in December; each person brought a gift to send overseas to the Rest-Breaks Homes.

Holy Family Hospital:

A welcome is extended to Rev. Sr. Irene as the new president of the Catholic Hospital Association for Saskatchewan. Mrs. C. Smith is now supervisor on the maternity ward. Ivy Mercer is on the staff of Kindersley Hospital. Sophie Savisky has taken up duties at Canora Hospital.

Prince Albert Sanatorium:

The staff donated $21.45 to the Cod Liver Oil Fund in connection with the Prince Albert Chapter. D. Smith, B. Sherwin, and E. Mengringe are recent appointments to the staff.

Victoria Hospital:

Mrs. E. Lewis is on temporary staff.

REGINA:

At a regular meeting of Regina Chapter, S.R.N.A., Mary E. Brown, president, and a bride-elect, was presented with an electric clock by Mrs. Davey on behalf of the members. The first vice-president, M. Palmer, will take up the duties of president.

General Hospital:

The following have left the staff to be married: Lorna Robinson, Lois Skuce, Hazel McDougall, Wanda Nordlund. The following are newcomers to the nursing staff: H. McFarlane, M. Buttrey, V. Illsley.

Grey Nuns' Hospital:

A successful tea was held recently by the student body. The proceeds were to be contributed to the Year Book Fund.

SASKATOON:

Dr. D. M. Baltzan spoke on "The Newer Aspects of Diabetes Mellitus" at a meeting of the Saskatoon Chapter, S.R.N.A.

City Hospital:

The alumnae association sponsored a tea and sale of work, with the handiwork and home-cooking booths being very successful.

E. Heieren has returned to the staff to supervise First West.

St. Paul's Hospital:

The Penny Carnival, held by the student nurses, proved a great success.

Miss Robinson and Rev. Sr. Quintal, clinical instructors, gave a demonstration to the nursing staff of the new continental iceless oxygen tent and electrocardiograph machine.

SWIFT CURRENT:

The Swift Current Chapter, S.R.N.A., will make an award to a Grade XII student who will be taking nursing as a vocation. A committee of three nurses — Mmes E. Powley, McKenzie, and Miss Patterson — was appointed to interview the girls interested.

Marjorie Mitchell and Olga Katarynych have joined the public health staff of Health Region 1.

Positions Vacant

Superintendent of Nurses for 16-bed modern Municipal Hospital at Eckville, Alberta. Duties to commence immediately if possible. For further information write to Sec.-Treas., Municipal Hospital No. 30, Eckville, Alta.

Graduate Nurses (2) for General Duty in a modern 16-bed hospital, very busy centre, at Eckville, Alberta. For further particulars write or wire collect to Sec.-Treas., Municipal Hospital No. 30, Eckville, Alberta.

Qualified Registered Nurse as Instructor for 150-bed General Hospital. 75 students. Duties to commence immediately. Salary: $150 per month plus $30 maintenance. Apply, stating qualifications, experience, age, and religion, to Supt. of Nurses, General Hospital, Chatham, Ont.

Supervisors for Student Nurse Affiliation Ward Teaching Program in Tuberculosis. Pleasant living accommodation. Hospitalization and Pension Plan. Apply to Supt. of Nurses, Freeport Sanatorium, Kitchener, Ont.

Operating-Room Supervisor for Galt Hospital, Lethbridge, Alberta. Apply to Supt. of Nurses.

Charge Nurse for Operating-Room. Charge Nurse for Obstetrical Dept. Apply to Secretary, Blanchard-Fraser Memorial Hospital, Kentville, N.S.

Visiting Nurses for outlying districts. Public Health course and experience desirable. **Hospital Nurses** for 10-bed hospitals. Staff of each consists of Matron and 3 Registered Nurses (with domestic staff in addition). For further information apply to the New Brunswick Division, Canadian Red Cross Society, 66 Prince William St., Saint John, N.B.

Assistant Superintendent. Salary: $125 per month and maintenance. 8-hour duty and 6-day week. Apply, stating age and experience, to Miss C. MacCullie, Supt., County of Bruce General Hospital, Walkerton, Ont.

Assistant Superintendent of Nurses for 130-bed hospital with Training School. Apply, stating qualifications, experience, and salary, to Supt. of Nurses, General & Marine Hospital, Owen Sound, Ont.

General Duty Nurses for St. Joseph's General Hospital, Comox, Vancouver Island, B.C. 76 beds. Salary: $135 gross monthly; full maintenance, $25.00. Laundry of uniforms. 6-day week. 9 statutory holidays. 28 days' vacation after 1 year's service. Apply to Supt. of Nurses.

Night Supervisor for 80-bed General Hospital in Simcoe, Ontario. Full maintenance, hospitalization, and sick leave. Apply, stating qualifications, date available, salary expected, etc., to Supt., Norfolk General Hospital, Simcoe, Ont.

Registered Nurse for General Staff at Tranquille Sanatorium which is situated on Kamloops Lake near Kamloops, B.C. Gross salary for 8-hour day, 6-day week: $145 per month plus $14.50 Cost of Living Bonus during 1st year. $10.00 raise per month during 2nd year and $5.00 per month raise in 3rd, 4th, and 5th years of service, minus $27.50 monthly for board, room, and laundry. 31 days' vacation per annum with pay, plus 11 days' statutory holidays. 14 days' sick leave each year accumulative, with pay, plus 6 days' incidental illness. Superannuation plan. Up to $50.00 of fare refunded. Apply to Supt. of Nurses, Tranquille, B.C.

350-bed Tuberculosis Hospital requires: **Night Supervisor** (attractive salary). **Graduate Nurses for General Staff Duty.** Starting salary: $110 per month plus full maintenance. Apply to Miss C. Louise Bartsch, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P.Q.

Matron. Salary: $150 per month plus maintenance. **Graduate Nurses (2).** Salary: $120 per month plus maintenance. 16-bed hospital. Apply to Municipal Hospital, Magrath, Alta.

Qualified Dietitian for General Hospital. Good salary and full maintenance. Apply to Administrator, General & Marine Hospital, Owen Sound, Ont.

Nursery Supervisor with post-graduate experience. Apply, stating qualifications and experience, to Supt. of Nurses, General & Marine Hospital, Owen Sound, Ont.

Public Health Nurse for Generalized Public Health Nursing Service. Must be bilingual (French & English). Apply to Supervisor, Public Health Nursing, Prescott & Russell Health Unit, Hawkesbury, Ont.

General Staff Nurses at $140 per month living out, plus laundry. **Operating-Room and Recovery Room Nurses** (Post-Graduate course essential) at $145 per month living out, plus laundry. Annual increment, accumulative sick leave, hospitalization, superannuation, 31 days' vacation, statutory holidays, 8-hour day and 6-day week. State in first letter date of graduation, experience, references, etc., when services would be available, and whether eligible for registration in British Columbia. Apply to Director of Nursing, Vancouver General Hospital, Vancouver, B.C.

Graduate, Registered Nurse for **Floor Duty** by January 1. Salary: $100 per month; full maintenance; increase of $5.00 per month after 1 year's service, up to 3 years. 8-hour duty. Blue Cross Hospitalization. Apply to Supt., Barrie Memorial Hospital, Ormstown, P.Q.

Registered Nurse with Public Health training to take charge of health and attendance programs in schools under Richmond-Drummond-Arthabaska Protestant Central School Board. Full-time work; holidays with pay; salary and travelling expenses. Duties to begin about April 1. Apply, giving full particulars of training, experience, and references, to C. W. Dickson, Supervisor, Box 207, Richmond, P.Q.

General Duty Nurses for 80-bed General Hospital. Salary: $115 per month (including pay for O.R. call and bonus) plus maintenance. Increase at end of 6 months to $120 and at end of 1 year to $125. 8-hour day and 6-day week. 2 weeks' holiday with pay (3 weeks given at end of 2nd year). Allowance for sick leave, hospitalization, and statutory holidays. Additional $5.00 per month paid for 3:30 shift. Apply, stating qualifications and date available, to Supt., Norfolk General Hospital, Simcoe, Ont.

Registered Nurses for Pediatric-Orthopedic Hospital. 8-hour day and 6-day week. Full maintenance or live out as desired. For further particulars apply to Supt., Shriners' Hospitals for Crippled Children, Montreal Unit, P.Q.

Graduate Nurses for General Duty. Salary: $100 per month and full maintenance. Apply to Supt., General Hospital, Kenora, Ont.

Night Supervisor. Salary: $130 per month and full maintenance. Apply to Supt., General Hospital, Kenora, Ont.

"To Bring Book-worms to Book"

The following is taken from a book-plate found in one of the Library's 17th Century books. We cannot be sure of the date of the book-plate itself, but 1859 has been written under the plate. The owner's name does not appear:

A Pleader to the Needer When a Reader

As all, my friend, through wily knaves, full often suffer wrongs,
Forget not, pray, when it you've read, to whom this book belongs . . .
Care take, my friend, this book you ne'er with grease or dirt besmear it;
While none but awkward *puppies* will continue to "dog's-ear" it!
And o'er my books when book-*worms* "*grub*," I'd have them understand,
No marks the margins must de-*face* from any busy "*hand*"!
Marks, as re-marks, in books of Clark's, when e'er some critic spy leaves,
It always him so *wasp*-ish makes, though they're but on the *fly*-leaves!
Yes, if so they're used, he'd not de-*fer* to *deal* a fate most meet —
He'd have the soiler of his *quires* do penance in a *sheet!*
The Ettrick *Hogg* — ne'er deem'd a *bore* — his candid mind revealing,
Declares, to beg "a copy" now's a mere pre-*text* for stealing!
So, as some knave to grant the loan of this my book may wish me,
I thus my book-*plate* here display, lest some such "fry" should dish me!
— But hold,— though I again declare with-holding I'll not *brook*,
And "a *sea* of trouble" still shall take to bring book-worms "to *book*"!

— *American Army News*